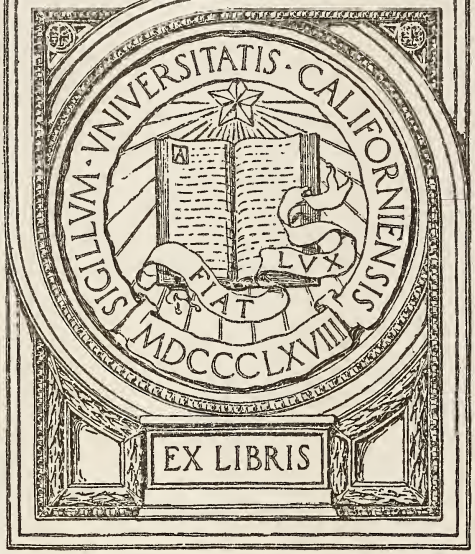
MEDICAL SCHOOL
LIBRARY



Digitized by the Internet Archive
in 2016 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/neworleansmedica53unse

NEW ORLEANS

MEDICAL AND SURGICAL

JOURNAL.

INDEX TO VOLUME FIFTY-THREE.

JULY, 1900,

TO

JUNE, 1901.

NEW ORLEANS:
L. Graham & Son, Ltd., Printers, 207-211 Baronne St.
1901.

UNIV OF CALIF
MEDICAL SCHOOL

INDEX TO VOLUME FIFTY-THREE.

JULY, 1900, TO JUNE, 1901.

CONTRIBUTORS OF ORIGINAL ARTICLES.

ARCHINARD, JOHN J., M. D.
BIBB, R. H. L., M. D.
BARRIER, J. M., M. D.
BARROW, S. C., M. D
BOUVIER, J. G., M. D.
BRUNS, H. D., M. D.
CHAILLÉ, S. E., A. M., M. D., LL. D.
CHASSAIGNAC, CHAS., M. D.
COLOMB, B. A., M. D.
DELAUP, S. P., B. SC., M. D.
DUPAQUIER, E. M., M. D. (PARIS).
DYER, ISADORE, PH. B., M. D.
FEINGOLD. M., M. D.
FENNER, E. D., M. D.
GAINES, G. W., M. D.
GUTHRIE, J. B., M. D.
HAYS, G. A. B., M. D.
LANDFRIED, C. J., M. D.
LEBEUF, L. G., M. D.
LEE, GEO. H., M. D.
LEHMANN, V., M. D.
LERCH, OTTO, A. M., PH. D., M. D.
MARTIN, E. D., M. D.
MCILHENNY, M. C., M. D.
MILLER, C. JEFF., M. D.
NOTO, COSIMO, M. D.
ODOM, T. B., M. D.
OECHSNER, JOHN F., M. D.
PARHAM, F. W., M. D.
PERKINS, W. M., M. D.
ROBERTSON, A. R., M. D.
ROUSSEL, J. N., M. D.
SAUTER, CHAS. F., M. D.
STORCK, J. A., M. PH., M. D.
TERRETT, B. A., M. D.
WILLE, A. G., M. D.

A.

Abdominal versus Vaginal Hysterectomy for Cancer of the Uterus 482
About Heredity 500
Abscess of the Orbit following injury 492
Acetanilid Habit, Case of, G. W. GAINES, M. D 30
Adenoids, Persistent, in a Woman of Forty-Seven 102
Alcohol as an Etiologic Factor in Diseases of the Nervous System, E. M. DUPAQUIER, M. D 247
Alcohol, Ingested by the Mother Passed to the Fetus 232
Amaurosis from Methyl Alcohol 781
Amenorrhea, for 233
American Academy of Medicine 51
American Medical Association Meeting of 1900 53
Analgesia from Subcutaneous Injection of Peroxide of Hydrogen 545
Anesthesia by Spinal Injection—Bier-Corning Method 276
Anesthesia of the Skin by the use of an Electric Current 47
Ankylosis of the Temporo-Maxillary Articulations: with Osteoclasis and Formation of New Joints—PAUL A. MCILHENNY, M. D 586
Antiseptics, Urinary 47
Archinard, John J., M. D. Disinfection From a Purely Practical Point of View. Its Efficiency a Problem for Solution 639
Asthma and Pregnancy 675
Atresia of Larynx, Due to Traumatism from Faulty Intubation 555

22730

B.

Barrier, J. M., M. D. Strychnin—Its Clinical Uses 719
Barrow, S. C., M. S. Variola, its Symptomatology, Complications, Diagnosis, etc., as learned from 100 cases in Shreveport Pesthouse 121
Benefit from Removal of Enlarged Tonsils and Adenoid Vegetations in Childhood 555
Bibb, R. H. L., M. D. Additional Notes on the Nature and Treatment of Leprosy 443
Biliary or Hepatic Colic, Treatment of 549
Black Tenias 97
Black Vomit and Hematemesis in Appendicitis 676
Blepharospasm, Two Cases of Severe, and Facial Chorea, Relieved by the use of Spectacles, by Drs. Bruns & Robin 79
Bloodletting and Subcutaneous Saline Infusions in Grave Toxic and Infectious Conditions 422
Bouvier, J. G., M. D. Unusual Behavior of Corneal Placental Implantation 327
Bromide of Ethyl Anesthesia in the Rose Position 164
Bromide of Rubidium in Epilepsy 285
Bruns & Robin, Drs. Traumatism of Eye, Discrepancy between Cause and Effect 661
Two Cases of Severe Blepharospasm and Facial Chorea Relieved by the Use of Spectacles 79

C.

Cancer, Etiology of 765
Cancer, Serum Injection for the Cure of 776
Cancer, Treatment of 674
Cancer of the Stomach, Treatment of 488
Cannabis Indica, Pharmacology of 45
Cardiac Embolus Following Forceps Delivery, Relation of a Case; Death Fifteen Days Later—L. G. LeBeuf, M. D 575
Cardiac Murmurs in Eruptive Fevers 96
Catarrhal Affections of the Upper Air Passages, Indications, Constitutional Treatment of 103
Catarrhal Deafness Treated with Pilocarpin 49
Cerebro-Spinal Meningitis, Ocular Findings in 105
Cerebro-Spinal Meningitis, of Aural Origin, a Case of 357
Cesarean Section, Symphyseotomy and Craniotomy in Contracted Pelvis, the Indications for 154
Chaillé, S. E., A. M., M. D., L. L. D. Annual Report of 1901, with an Historical Summary of Educational Progress, to the President of Tulane University at Commencement of Medical Deparment 725
Chalazion, Etiology and Treatment of 432
Charity Hospital of Louisiana Alumni Association 663
Charity Hospital Notes:
Acute Lobar Pneumonia, Case of (Epitome of Lecture), John B. Elliott, M. D 459
Comatose Malaria, with Chronic Endocarditis, a Case of, P. L. Cusachs, M. D 338
Complete Ablation of the Scapula, S. P. Delaup, M. D 270
Ectopic Pregnancy; Operation; Death, M. J. Magruder, M. D. 85
Fibrinous Pleurisy, Case of, John B. Elliott, M. D 529
Halsted Operation for Carcinoma of Breast, Modified, E. Denegre Martin, M. D 83
Hypertrophy of the Vulva; Operation—*Illustrated*, Hamilton P. Jones, M. D 337
Hysterectomy, Supra-vaginal, for Intra-Mural Fibroids, C. Jeff Miller, M. D 146

Charity Hospital Notes:—*Continued.*
Neuro-Regional Anesthesia for Amputation of a Finger, with its Metacarpal for Epithelioma, R. Matas, M. D 415
Plastic Nose Constructed after a Syphilitic Destructive Process—*Illustrated*, E. Denegre Martin, M. D 219
Removal of Keloids, Local Anesthesia, H. B. Gessner, M. D. 31
Salpingitis; Cystic Ovary; Adherent Omentum, J. Leo Burthe, M. D..... 271
Splenectomy, H. S. Cocram, M. D..... 144
Chassaignac, Chas., M. D. Spinal Anesthesia in Rectal Cases..... 403
Cholera Infantum 235
Choroiditis, Purulent..... 780
Chronic Gastritis with Erosions—A Clinical Lecture, Otto Lerch, M. D..... 656
Ciliary Body, Recurring Hemorrhages from..... 780
Cirrhosis of the Liver, Hypertrophic, Geo. S. Bel, M. D..... 146
Clinical Hints in Brain Disease 159
Cocain and Eucain in Local Anesthesia, as Applied by Combined Methods, B. A. Terrett, M. D..... 513
Coffee Intoxication..... 284
Colomb, B. A., M. D.—For Ingrown Nails..... 333
Suggestions for the Treatment of Gastro-Intestinal Ailments of Children 133
Copper Poisoning..... 554
Corneal Placental Implantation, Unusual Behavior of—J. G. Bouvier, M. D..... 327
Curettage of the Attic of the Tympanum, etc., New Method for, in Middle Ear Suppuration..... 356

D.

Dandruff, Its Treatment, J. N. Roussel, M. D 749
Deafness, Perversion of Taste and Facial Paralysis Associated with Herpes 617
Degenerates and Marriage..... 501
Delaup, S. P., Bs. C., M. D. Dermoid Cyst of the Scalp, with a Report of a Case 645
Delirium Tremens, Treatment of by Injection of Artificial Serum 241
Dermatitis Exfoliativa Recurrens, Report of a Case of, A. R. Roberson, M. D..... 68
Dermoid Cyst of the Scalp, with a Report of a Case, S. P. Delaup, M. D. 645
Diabetes and Pregnancy..... 675
Digitalis, Action of on the Kidney..... 284
Digitalin and Other Derivatives of Digitalis in Surgical Shock, the Real Value of 227
Disinfection from a Purely Practical Point of View. Its efficiency a Problem for Solution, John J. Archinard, M. D..... 639
Diuretics, the use of 486
Diuretics by the Rectum..... 233
Double Intraligamentous Cyst, a Case of, with remarks, C. Jeff Miller, M. D 265
Dupaquier, E. M., M. D. Alcohol as an Etiologic Factor in Diseases of the Nervous System..... 247
Lung Infarction and Pneumonia in Cardiopathies, etc..... 651
Measles and Small Pox in Children 8
Scarlatina and Diphtheria, a Case with Bacteriologic Examination, etc..... 755
Dyer, Isadore, Ph. B., M. D., A Note on the Medical Relief Work done in Galveston after the Storm..... 261
The Commoner Affections of the Hands and Feet and their Treatment..... 321

E.

Eclampsia, Chloroform and Chloral for 39
Edema of the Lungs 157
Effervescent Quinin Mixture 286
Emergency Hospital at the Pan American Exposition 619
Empyema of the Maxillary Antrum, Tubercular 87
Endowment of Medical Colleges—*Editorial* 290
Enucleation of an Eye Ball—Indications for 352
Ethyl Alcohol, Relation of, to the Nutrition of the Animal Body 358
Euquinin in Acute Nasal Catarrh 532
Evils of Alcohol—*Editorial* 106
Eye Strain, Common but Generally Unrecognized Symptoms of 104

F.

Facial Paralysis Complicating Acute Otitis Media 588
Feingold, M., M. D., Three Cases of Ocular Disease 135
Fenner, E. D., M. D., Acute Rheumatism in Childhood, with Report of Two Cases 74
Typhoid Fever in Childhood with a Report of Three Cases. 105
Foreign Bodies of Nose and Ear, New Method for Removal of 48
Formaldehyd in Rhinology, Use of 288
Formalin in Ophthalmology 607
Fracture of the Anterior Floor of the Skull, with Consequent Meningitis. Recovery after Trephining 1
Fracture of the Patella, Simple; With Suggestions as to Treatment.—The Riveting of Other Bones, etc.—*Illustrated*, E. D. MARTIN, M. D.

G.

Gaines, G. W., M. D., Case of Acetanilid Habit 30
Gall Stones and Hydatid Cyst of the Liver 282
Gallstones, on the Treatment of (Abstract of Lecture). F. P. HENRY, M. D 333
Galveston After the Storm, A Note on the Medical Relief Work Done In—ISADORE DYER, M. D 261
Gastro-Intestinal Ailments of Children, Suggestions for the Treatment of, B. A. COLOMB, M. D 133
Gelatin Injections for Aneurism 427
Gigli's Latest Modification of Instruments and Technic in Craniotomy, etc 480
Guthrie, J. B., M. D., A Case of Acute Phosphorus Poisoning, with Demonstration of Post Mortem Findings 253

H.

Hair, During and After Fevers, Management of 234
Hands and Feet, Commoner Affections of, and Their Treatment—ISADORE DYER, M. D 321
Hays, G. A. B., M. D., Care and Treatment of the Insane 20
Healthful New Orleans—*Editorial* 224
Hepatic Cirrhosis, Surgical Treatment of 605
Hemophilic Extravasation into the Conjunctiva 779
Hereditary Syphilis, Importance of Early Diagnosis In—A Case in Point, JOHN F. OECHSNER, M. D 405
Hip Joint Amputation by the Method of Wyeth, Three Successful Cases, F. W. PARHAM, M. D 208

Home for Louisiana Consumptives—*Editorial* 592
Hydrogen Peroxide by Subcutaneous Injection for Local Anesthesia 344
Hypertrophy of the Left Ventricle in Plain Stenosis of the Mitral, Cosimo Noto, M. D 524
Hypodermoclysis, Some Facts About 614
Hypospadias, Operation for Severe Perineo-Scrotal—*Illustrated*—F. W. Parham, M. D 449
Hypospadias and Epispadias, with Special Reference to their Operative Treatment—*Illustrated*—F. W. Parham, M. D 373
Hypospadias Treated by Beck's Method 151
Hysteric Pseudo-Appendicitis 613

I.

Ichthyol in Atrophic Fetid Rhinitis 357
Illegal Compounding of Prescriptions—*Editorial* 35
Infarcts of the Placenta 93
Influenza, Treatment of 438
Ingrown Nails, for, B. A. Colomb, M. D 383
Improvements with New Volume—*Editorial* 33
Insane, Care and Treatment of, G. A. B. Hays, M. D 20
International Congress of Deontology and Professional Medicine, Paris, 1900 172
International Medical Congress, Paris, 1900 ..... 173, 229, 236, 286, 291
Intraocular Metallic Foreign Bodies, Two Cases of 491
Intraspinal Injection of Cocain, Effect upon the Circulation of the Dog. 544
Iridectomy with Removal of Lens Capsules, etc., in Blindness of over 13 Years, with Recovery of Vision 51

J.

Jaundice, Treatment of Acute (Abstract of Lecture), J. C. Wilson, M. D 80

K.

Kaiserling Solution for Preserving Specimens 86
Kidney, Medical Treatment in Diseases of, L. G. LeBeuf, M. D 311
Koch's Investigations of Malaria 493

L.

Labor with Triplets, Case of, T. B. Odom, M. D 528
Landfried, C. J., M. D., Case Illustrative of the Absence of Ordinary Acute Tympanic Signs in Acute Suppurative Mastoiditis Following Abscess of the Middle Ear; Operation; Death 203
Laryngeal Diphtheria, Tracheotomy, Antitoxin Injections; Recovery, John F. Oechsner, M. D 405
Laryngeal Stenosis Following Tracheotomy, Explanation of the Cause of 616
Laryngeal Tuberculosis, for 556
Laryngeal Tuberculosis, Treatment of 678
Laryngeal Diphtheria in Children, Points in the Differential Diagnosis of 103
LeBeuf, L. G., M. D., Medical Treatment in Diseases of the Kidney 311
Ptomain Poisoning, Duration of Cases in Children 742
Relation of a Case of Cardiac Embolus Following Forceps Delivery; Death 15 Days Later 575

Lee, Geo. H., M. D., a Case of Rhinoplasty 331
Lehmann, V., M. D., Improved Method of Vaccination, Vaccinoid..... 130
Successful Treatment of Variola..... 128
Leper Home, The, and the Legislature—*Editorial*..... 33
Leprosy, Additional Notes on the Nature and Treatment of—*Illustrated*—R. H. L. Bibb, M. D..... 443
Lerch, Otto, A. M., Ph. D., M. D., Chronic Gastritis with Erosions..... 656
Concomitant Measles, Chicken-Pox and Small-Pox..... 61
Leukemia of Tonsillar Origin, a case of Acute..... 490
Lingual Trans-plantation for closure of Cleft Palate..... 164
Local Anesthesia in Hemorrhoidal Operations..... 623
Loss of Hair..... 427
Louisiana State Medical Society Meeting 681-706
Louisiana State Medical Society Notes..171, 297, 362, 434, 503, 560, 626, 681
Lung Infarction and Pneumonia in Cardiopathies. A case with Post Mortem Examination, E. M. Dupaquier, M. D..... 651

M.

Malarial Fevers, For..... 99
Martin, E. Denegre, M. D., Simple Fracture of the Patella: With some Suggestions as to Treatment. The Riveting of Other Bones, etc..... 1
Spinal Analgesia 453
Mastoiditis, Acute Suppurating, Following Abscess of the Middle Ear. Case Illustrating the absence of ordinary Acute Tympanic Signs, etc., C. J. Landfried, M. D..... 203
Mastoiditis, Treatment of Acute, in Adults and Children..... 778
McIlhenny, Paul A., M. D., Ankylosis of the Temporo-Maxillary Articulation: With Osteoclasis and Formation of New-Joints..... 586
Measles and Small Pox in Children, E. M. Dupaquier, M. D..... 8
Measles, Chicken-Pox and Small-Pox, Concomitant, Otto Lerch, M. D..... 61
Mechanic Dilatation in Obstetric Practice, Scope of Immediate..... 280
Medical News Items: Personals, Deaths, General News, etc....51, 113, 172 242, 297, 363, 435, 505, 562, 629, 706, 782
Medullary Narcosis During Labor..... 278
Mercurol..... 359
Methyl Salicylate..... 775
Miller, C. Jeff, M. D., Case of Supra-Vaginal Amputation of the Uterus for Fibroids Complicating Pregnancy..... 581
A case of Double Intraligamentous Cyst, With Remarks..... 265
Mitral Stenosis and Chlorosis (Abstract of Lecture), F. P. Henry, M. D 218
Modification of Milk..... 616
Mortuary Report.....60, 120, 184, 246, 310, 372, 442, 512, 574, 638, 718, 790
Murphy Button, Modification of, for Gastro-enterstomy to Prevent Its Falling Into the Stomach..... 151
Myopia, High, Operative Treatment In.....165, 290

N.

Naphthol in Therapeutics, Uses of..... 100
Nasal and Naso-Pharyngeal Affections Treated With Hot Air..... 430
Neuralgia, Treatment of by Acupuncture 613
New Form of Mercury in Syphilis..... 624
New Instrument: A Needle for Silver Wire—L. J. Y. Genella, M. D. 662
New Orleans College of Pharmacy Organized..... 114
New Orleans Polyclinic's New Faculty Members..... 113

New Remedies: Antipneumonic Serum, 99; Basicin, 45; Coto-Bark, 98; Dionin, 161; Epicarin, 160; Fersan, 678; Largin, 44; Levurin, 45; Myrtol, 425; Petro-Sulfol, 234; Sodium Meta-Vanadate, 426; Tannalbin, 161; Tannoform, 97; Tropa-Cocain Hydrochlorid 677
Nirvanin in Rhinology, Laryngology and Otology 56
Nitric Acid for Gonorrhea 480
Noto, Cosimo, M. D., On Hypertrophy of the Left Ventricle in Plain Stenosis of the Mitral 524

O.

Obituary on Dr. Paul von Seydewitz 632
Obstetric Surgery of Pelvic Contraction, Observations On 346
Obstetrics, Report of a Case in the Practice of A. G. Wille, M. D. 458
Ocular Disease, Three Cases of, M. Feingold, M. D 588
Odom, T. B., M. D., Case of Labor With Triplets 528
Oechsner. Jno. F., M. D.—1. Importance of an Early Diagnosis of Hereditary Syphilis. 2. Larygneal Diphtheria; Tracheotomy; Antitoxin Injections; Recovery 405
Ophthalmia, Sympathetic, caused by Glioma of the Retina 165
Ophthalmia, Sympathetic, Treated by Sodium Salicylate 50
Ophthalmology, Section on, at College of Physicians in Philadelphia 556, 618, 680
Organotherapy in China 231
Orleans Parish Medical Society Proceedings 465, 535, 596, 670, 761
Oxyuris in the Appendix of Children 43

P.

Pan American Medical Congress—*Editorial* 418
Parham, F. W., M. D., Hypospadies and Epispadies with Special Reference to their Operative Treatment 373
Operation for Severe Perineo-Scrotal Hypospadias 449
Three Successful Cases of Hip Joint Amputation by the method of Wyeth 208
Parturient Womb, Contribution to Treatment of Rupture of, with Critical Review of Vaginal Operation 94
Patent Medicines and Honest Pharmacy—*Editorial* 273
Pelvic Inflammation Masses Removed by the Abdomen, after Bisection of the Uterus 421
Peripheral Neuritis, Case of, (Abstract of Lecture) Chas. Wells, M.D 142
Peri-tonsillar Abscess Associated with Diphtheria 163
Perkins, W. M., M. D., Prophylaxis of Surgical shock 195
Petroleum in Therapeutics 621
Phosphorous Poisoning, Case of Acute, with Demonstration of Post-Mortem Findings—*Illustrated*—J. B. Guthrie, M. D 253
Physicians' Incomes—*Editorial* 666
Physiologic Standardization of Drugs 433
Pilocarpin in Inflammations of the Eye 781
Pink Eye, for 358
Placental Transmission 420
Pleurisy, Appendicular 42
Pneumonia, Contagiousness of 771
Pneumonia, Ice Bags in 773
Pneumonia after Surgical Injury (abstract of Lecture) A. V. Meigs, M. D 140

Pneumonia in the Obese 486
Pneumonia, The Abortive treatment of, Catarrhal and Croupous, in Infants and Children 484
Postgraduate Instruction—*Editorial* 533
Post Partum Hemorrhage, The Prevention and Treatment of 345
Potassium Iodide in Ophthalmic Practice 431
Practical Points on Muco-Membranous Colitis 349
Pregnancy Complicating Carcinoma of the Cervix 547
Pregnancy, Treatment of Tumors Complicating 40
Prevention of Premature Burial—*Editorial* 223
Prophylaxis of Surgical Shock, W. M. PERKINS, M. D 195
Protargol 625
Psychic Influence in the Practice of Medicine 777
Psychologic Problems Relating to Confessions of Innocent Persons 167
Protozoon of Cancer, Dr. Gaylord's Work Upon—*Editorial* 758
Publications received: 59, 119, 183, 245, 308, 370, 440, 511, 572, 636, 716 788
Puerperal Infection, Present Status of the Treatment of 546
Puerperal Insanity 769
Puerperal Sepsis, the Surgical Treatment of 608
Pulmonary Tuberculosis, On the Early Diagnosis of 550
Pulmonary Tuberculosis Treated with Intravenous Injections of Hetol 101

Q.

Quinin Bichloride in Cancer 235
Quinin in Malignant New Growths 283

R.

Radiography in Penetrating Revolver Wounds of the Skull 608
Resuscitation after Suffocation, Chloroform Poisoning, and Electric Shock 272
Rheumatism, Acute, in Childhood with Report of Two Cases, E. D. FENNER, M. D. 135
Rhinitis, Atrophic, caused by Purulent Rhinitis of Childhood 164
Rhinoplasty, A Case of—*Illustrated*. Geo. H. LEE, M. D. 331
Rickets in Children, Treatment of 101
Rice for Feeding Cases of Gastric Ulcer 425
Robertson, A. R., M. D., Case of Dermatitis Exfoliativa Recurrens ... 68
Roussel, J. N., M. D., Dandruff, Its Treatment 749
Rubber Balloon in Obstetrics, the Intra Uterin use of 347

S.

Sauter, Chas. F., M. D., Suprarenal Liquid with Chloretone in Rhinology 591
Scarlatina and Diphtheria, a Case with Bacteriologic Examination, E. M. DUPAQUIER, M. D. 755
Separate Accommodation for Consumptives—*Editorial* 341
Serum Mystery in Milan 545
Shock and Infection—Some Methods of Preventing 225
Skull Defects, The Closure by Bone of 479
Small Pox in New Orleans and Elsewhere 110
Smith's Signs 350
Southern Surgical and Gynecological Association 360
Spinal Analgesia, E. DENEGRE MARTIN, M. D. 453
Spinal Anesthesia in Rectal Cases, CHAS. CHASSAIGNAC, M. D. 403
State Medical Society—*Editorial* 593

State Society Meeting—*Editorial* 462
Sterilizing Hands and Field of Operation, New Method for 90
Storck, J. A., M. Ph., M. D. Tuberculosis 185
Strychnin, Its Clinical Uses. J. M. Barrier, M. D 719
Sudden Death by Inhibition 611
Sunstroke 236
Suprarenal Capsule in Diseases of the Lower Air Passages 553
Supra-Renal Extract in Intra-Nasal Surgery, Secondary Hemorrhage Following the Use of 147
Suprarenal Liquid with Chloretone in Rhinology. Chas. F. Sauter, M. D 591
Supra Vaginal Amputation of the Uterus for Fibroids Complicating Pregnancy, a case of: C. Jeff. Miller, M. D 581
Suspension of the Uterus on the Round Ligaments 280
Syphilis, a Few Notes on Obscure Cases of; Relation of two Cases of Extragenital Chancre—L. G. LeBeuf, M. D 24
Syphilitic Ulceration of Larynx and Acute Edema of Glottis, Treatment of (Abstract of Lecture), Emma E. Musson, M. D 335

T.

Teach Physiologic Truths—*Editorial* 89
Tendon Transplantation in Deformities of the Hand 91
Terrett, B. A., M. D., Cocain and Eucain in Local Anesthesia, etc 513
Tesla's Electric Unit—*Editorial* 150
Tetanus Treated with Brain Emulsion 148
Texas Health Board 179
Texas Medical Practice Law—*Editorial* 340
The Mosquito Theory of Yellow Fever—*Editorial* 593
The New Medical Law of Texas—*Editorial* 593
The New President of Tulane—*Editorial* 274
The New Year—*Editorial* 419
The State Medical Society Meeting—*Editorial* 664
Third Pan American Medical Congress—*Editorial* 342
Tobacco Amblyopia 51
Tonsillitis 431
Tonsillitis, Radical Treatment of Acute Follicular 49
Tooth Growing from Orbital Wall of Maxillary Sinus 430
Traumatic Dislocation of the Face 343
Traumatic Neurosis, Interesting Examples of (Abstract of lecture)—F. X. Dercum, M. D 81
Traumatism of Eye; Discrepancy between Cause and Effect. Drs. Bruns & Robin 661
Tuberculosis, J. A. Storck, M. D 185
Tuberculosis and Some Medications 295
Tuberculosis, Legal Prevention of 107
Tuberculosis of the Maxillary and Sphenoidal Sinuses, Causing Death 779
Tulane Medical Department, Annual Report of Dean, etc., S. E. Chaillé, M. D 725
Tuning Fork as a Test for Disease of the Maxillary Antrium 617
Typhoid Fever Complicated with Pneumonia (Abstract of lecture). Arthur V. Meigs, M. D 412
Typhoid Fever in Childhood, with a Report of Three Cases, E. D. Fenner, M. D 74
Typhoid Fever, Treatment (Abstract of lecture), F. P. Henry, M. D 214

U.

Uphold a High Ethic Standard in Medical Journals—*Editorial* 463

V.

Vaccination, Improved Method of, Vaccinoid, V. LEHMANN, M. D. ... 130
Variola, Successful Treatment of, V. LEHMANN, M. D. ... 128
Variola—Its Symptomalology, etc., As seen at Shreveport Pest House House in January and February, 1900, S. C. BARROW, M. S. ... 121
Vesicovaginal Fistula, New Method for ... 771
Vibratory Massage By Means of a Sound in Diseases of the Upper Air Passages ... 429

W.

White Plague, The—*Editorial* ... 149
Whooping Cough ... 285
Whooping Cough Treated with Antitussin ... 427
Whooping Cough, Treatment of Paroxysmal Stage of ... 552
Wille, A. G., M. D., Report of a Case in the Practice of Obstetrics ... 458

Y.

Yule Tide—*Editorial* ... 341

BOOKS REVIEWED IN VOL. LIII.

Appendicitis, A Treatise on—DEAVER ... 508
Atlas and Abstract of Diseases of the Larynx—GRUNEWALD-GRAYSON. 570
Atlas and Epitome of Diseases caused by Accidents, An—GALEFIENSKI & BAILEY ... 508
Atlas and Epitome of Gynecology—SCHAEFFER ... 306, 568
Bacteriology and Surgical Technique for Nurses—STONEY ... 510
Biennial Report of the Board of Health of the City of New Orleans ... 182
Brain, Anatomy of the—WHITEHEAD ... 303
Cancer of the Uterus, Its Pathology, Symptomatology, Diagnosis and Treatment—CULLEN ... 507
Care of the Consumptive—GARDINER ... 509
Cyclopedia of Practical Medicine and Surgery—GOULD ... 180
Diabetes Mellitus and Glycosuria—KLEEN ... 438
Dictionary of Medical Sciences—DUNGLINSON ... 788
Dictionary of Medicine and the Allied Sciences—DUANE ... 243
Dictionary of Terms Used in Medicine and Collateral Sciences—HOBLYN ... 57
Diseases of the Heart, Their Diagnosis and Treatment—ABRAMS ... 634
Diseases of the Nose and Throat—BROWN ... 55
Diseases of the Stomach—HEMMETER ... 301
Diseases of Women; a Treatise on the Principles and Practice of Gynecology—DUDLEY ... 304
Enlargement of the Prostate—MOULLIN ... 118
Essentials of Medical and Clinical Chemistry, with Laboratory Exercises—WOODS ... 302
Essentials of Medical Diagnosis—ESHNER ... 243
Essentials of Physical Diagnosis of the Thorax—CORWIN ... 368
Essentials of Surgery—MARTIN ... 303
Essentials of Histology—LEROY ... 509

Eye, Ear, Nose and Throat—Ballenger-Wippern 633, 716
Food for the Sick and How to Prepare It—French 369
Fractures—Beck 509
Fractures, Treatment of—Estes 712
Gynecology—Crockett 306
Handbook for Nurses—Watson 58
Histology, Text-Book of—Böhm—von Davidoff—Haber—Cushing 571
Hygiene and Sanitation, a Manual of—Egbert 787
Injuries to the Eye in their Medico-Legal Aspect—Baudry—Ostheimer—Oliver and Sinkler 244
Imperative Surgery for the General Practitioner, Specialist and Recent Graduate—Lilienthal 181
International Clinics 244, 713
International Medical Annual 714
International Medical Annual and Practitioner's Index for 1900—Treat 57
International Text-Book of Surgery, by American and British Authors—Warren & Gould 302
Introduction to the Study of Medicine—Roger 713
Lea's Series of Pocket Text-Books: Chemistry and Physics—Martin & Rockwell 58
Histology and Pathology—Nichols & Vale 182
Nervous and Mental Diseases—Potts 181
Lessons on the Anatomy, Physiology and Hygiene of Infancy and Childhood—Cotton 369
Manual of Clinical Diagnosis by Means of the Microscope and Chemical Methods—Simon 368
Materia Medica and Pharmacology, Manual of—Culbreth 569
Materia Medica, Text-Book of Therapeutics and Pharmacology—Butler 118
Medical Dictionary, American, Illustrated—Dorland 510
Medical Dictionary, A Pocket—Gould 56
Medical and Surgical Nursing—O'Brien 182
Medical Diseases of Infancy and Childhood—Williams & Churchill 306
Medical News Visiting List for 1901 439
Medical Treatment of Diseases and Symptoms, Text-Book of—Tirard and Thornton 243
Medicine and Surgery, American Year Book of—Saunders 180
Medicine as a Business Proposition—Lydston 305
Mental Diseases, Treatise on—Berkley 367
Mentally Deficient Children—Shuttleworth 57
Modern Medicine—Salinger-Kalteyer 635
Normal Histology—Dunbar 307
Nose and Throat—Treatise on Diseases of the—Shurley 787
Nose and Throat, Diseases of—Kyle 715
Obstetric Clinics—Lewis 569
Obstetrics—Evans and Gallander 305
Obstetrics, Manual of—King 508
Operative Surgery, Manual of—Stimson and Rogers 570
Otology, Manual of—Bacon 302
Paralytic Deformities of the Lower Extremities—Smith 572
Pathogenic Bacteria, Text-Book on the—McFarland 571
Pathology, Text-Book of—Stengel 572
Pathology and Morbid Anatomy—Green-Murray-Martin 303
Pathology and Surgical Treatment of Tumors—Senn 369
Personal Hygiene, Manual of—Pyle 440
Physician's Visiting List for 1901—Blakiston 571, 712
Physiology, American Text-Book of, Vols. I and II—Howell 714
Physiology, Compendium of Human—Brubaker 440
Pilgrimage, or the Sunshine and Shadows of the Physician, A—Lowder

Practical Gynecology—Montgomery 567
Practical Treatise on Fractures and Dislocation—Stimson 509
Practical Treatise on Materia Medica and Therapeutics, with Reference to the Clinical Application of Drugs—Shoemaker 634
Practical Treatise on Medical Diagnosis—Musser 302
Practical Treatise on the Sexual Disorders of the Male and Female—Taylor 306
Practical Medicine, Text-Book of—Thompson 244
Practical Therapeutics, Text-Book of—Hare 301
Practical Uranalysis and Urinary Diagnosis—Purdy 368
Practice of Medicine, a Manual for Students and Practitioners—Malsbary 118
Practice of Medicine, Manual of the—Stevens 117
Practice of Medicine, Text-Book of the—Anders 635, 713
Principles of Treatment and their Application in Practical Medicine—Bruce & Thornton 117
Progressive Medicine—Hare 58, 369, 636, 714
Psychology of Sex, Studies in the—Ellis 307
Reference Hand-Book of the Medical Sciences—Buck 440, 636
Refraction and How to Refract—Thorington 308
Refraction of the Eye—Hartridge 301
Rhinology, Laryngology and Otology and their Significance in general Medicine—Friedrich-Curtis 634
Saunders' Pocket Medical Formulary 439
Skin, Compend of Diseases of the—Schamberg 509
Stringtown on the Pike--Lloyd 439
Student's Medical Dictionary--Gould 510
Suggestions to Medical Writers--Gould 181
Surgical Anatomy—Deaver 303
Surgical Diseases of the Genito-Urinary Tract, Venereal and Sexual Diseases—Lydston 510
Surgical Pathology and Therapeutics—Warren 304
Surgical Treatment, Manual of—Cheyne and Burghard 712
Therapeutics: Its Principles and Practice—Wood 569
Tuberculosis as a Disease of the Masses and How to Combat It--Knopf 715
Twentieth Century Practice of Medicine, Vol. XX 569
Urine, Clinical Examination of, and Urinary Diagnosis—Ogden 636
Women, Diseases of, Text-book of the—Garrrigues 568
Year Book of the Nose, Throat and Ear—Heard-Andrews 56, 633

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. JULY, 1900. NO. 1.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

SIMPLE FRACTURE OF THE PATELLA: WITH SOME SUGGESTIONS AS TO TREATMENT—THE RIVETING OF OTHER BONES, ETC.*

BY E. DENEGRE MARTIN, M. D.,
PROFESSOR OF MINOR AND CLINICAL SURGERY, NEW ORLEANS POLYCLINIC, NEW ORLEANS.

Though one or two of the suggestions which I propose to introduce in the course of this article are the results of a number of experiments, yet I doubt not that they have occurred to others working in the same field, but to my knowledge they have not been acted upon.

There is no fracture in the body which gives more anxiety to the surgeon, and although the results are usually good, there always exists a doubt, and under all circumstances the prognosis must be guarded.

First, as to the mechanism of these fractures. Some surgeons incline to the belief that simple transverse fractures may be due to traumatism alone. From experiments on the cadaver I do not believe such a thing is possible. If the injury is inflicted when the leg is flexed and the lower end of the patella slightly tilted such a thing is possible, but with the leg extended and

* Read before the Louisiana State Medical Society, April 19, 20, 21, 1900.

the patella resting on the femoral patellar surface with the muscles relaxed, a blow of sufficient force to cause a fracture would do serious damage to other structures of the joint. In these cases where I attempted to fracture the patella on the cadaver, I found it necessary to transfix the bone in several places along its vertical axis and use quite a little force before I could produce a fracture. When the leg is flexed and the full retractive force of the quadriceps causes it to be suddenly jerked upward while firmly anchored below by the ligamentum patellæ, the force is such as to cause a rupture at the weakest point; the ligaments, being more or less elastic, resist the shock, but the bone, being firm, receives the full force of the recoil and usually gives way. The muscular force exerted under such conditions is great and frequently results in widely separating the fragments; hemarthrosis is marked.

When, however, the fracture is caused by a blow, as falling on the knee, when the quadriceps is sufficiently contracted to make it tense, separation of the fragments is less, and hemarthrosis is slight. The mooted question of the day is the method of treating these fractures. We find surgeons divided on the subject of surgical interference, owing to the great danger of sepsis, so liable to result in impairment of the joint, and the many mechanical devices offered to the profession for treatment of fractures of the patella prove conclusively that no satisfactory plan has yet been suggested for the non-operative treatment.

There are undoubtedly two classes of these cases, those in which good results can be obtained without operation, and those in which the results without operation would be doubtful.

It has occurred to me that we might divide fractures of the patella into two classes—those occurring in very thin subjects where separation of the fragments is not wide, and hemorrhage slight; and those occurring in fat subjects where the same conditions exist; in the former, arthrotomy is not necessary. The fractured ends of the bone can be easily brought into apposition and held in place. This is best accomplished, I believe, by encasing the leg in plaster with a fenestrum at the knee sufficiently large to expose the patella. A splint moulded from gauze or blanket, V-shaped and soaked in plaster, fitted behind each fragment and held in position by a figure-of-eight bandage, I have found most effectual in keeping the bones in close apposition. Slight pres-

sure should also be made over the site of fracture to prevent tilting. If the pre-patellar tissues are found to be interposed between the fragments of bone and prevent close apposition, they can be lifted by inserting a straight needle through the tissues between the fragments.

In the latter class, owing to the interposition of a mass of adipose tissue such treatment will not insure satisfactory results, and these cases, I believe, should be operated upon when the patient's health and surrounding conditions will permit.

Where, however, the fragments are widely separated, hemarthrosis marked, showing extensive laceration and the pre-patellar tissues interpose between the fragments, I believe operative interference essential.

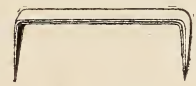
In the non-operative cases we have many obstacles to union, dependent more or less upon the extent of injury—viz: separation of fragments due to contraction of the quadriceps; tilting of fragments; rupture of the capsule; effusion of blood; intervention of pre-patellar tissues; arthritis and other causes of more or less importance, all of which must be taken into consideration in the treatment of these fractures. The method of non-operative treatment which appeals most to me is that of massage introduced by Tilanus. This has one serious objection, that unless done properly will prove a failure, and how many surgeons are prepared to carry out the treatment as described? Fixation is then the method of non-operative procedure that will be adopted by the majority of surgeons. I have found the method described heretofore as practical as any. By the fixation method, massage cannot be done and adhesions will form. It is in making passive motion to break up these adhesions that the great danger lies. The joint becomes ankylosed while the leg is fully extended; the adhesions form in the joint. These often give way suddenly and the full force exerted by the operator being suddenly thrown on the patella, through the short and powerful ligamentum patellæ, causes separation of the fragments at the seat of fracture. This accident I have seen occur twice very recently. I have found as soon as the leg could be flexed to 110 or 115 degrees that no passive motion beyond continued use of the limb was required, and patients would gradually regain entire control of the leg. If, then, the danger lay in flexing the leg, the first few times passive motion is made, it is important

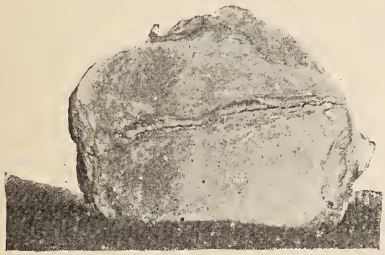
to obviate this danger. To do this *I would suggest putting the leg up in a plaster cast at an angle of 100 degrees.* This is a slight flexion of only 10 degrees. The position is more comfortable to the patient and in no way interferes in maintaining the fracture in proper position. At the end of four weeks the cast can be split anteriorly from the knee down and passive motion begun by extending instead of flexing the leg, and the adhesions around the patella broken up by passive and gentle contraction of the quadriceps. This can be done every day for two weeks, at the end of which time the cast can be replaced with a lighter bandage and the patient allowed to walk around on crutches. The limited amount of motion gained in this way will increase perceptibly from day to day. An anesthetic should never be given to break up the adhesions, as under an anesthetic there is danger of exerting unnecessary force, frequently resulting in separating the fragments at the line of union and undoing all the good already accomplished.

If the surgeon should elect to operate, the simplest method and that requiring the least amount of manipulation is the one that should naturally suggest itself.

The methods in vogue are not ideal, as they frequently allow separation of the fragments. This I was enabled to overcome in a recent operation by modifying the cerclage method. A heavy silver wire was passed through the tendon of the quadriceps and the ligamentum patellæ, and brought over the top of the patella about half an inch apart; this was drawn very tightly and by suturing the periosteum, kept the fragments in perfect apposition, resulting in bony union. The great objection to the use of wire and other sutures is that these either stretch or cut through the soft tissues. After mature consideration of the subject, the result of a number of experiments, I found that these objections could be overcome by a very simple procedure. What is most desirous in arthrotomy for fractured patellæ is a simple, quick and effective procedure. In testing the many methods recommended, I found that as the patella was porous, a nail could be driven into it without doing great damage to the bone or causing a fracture. I then determined to fasten the fragments of bone with a staple made of simple wire, and of sufficient size to have the requisite strength. These staples

were made with beveled shanks about five-eighths of an inch in length and bent at right angles about one-half to three-fourths of an inch apart. A small hole was drilled into the bones half the depth of the length of the shank, the fragments placed in apposition and the staples driven into the bone in such a manner as to draw the fragments closer together. These staples will keep the bone in perfect apposition and prevent tilting, are simple and quickly applied, requiring very little manipulation of the fragments.

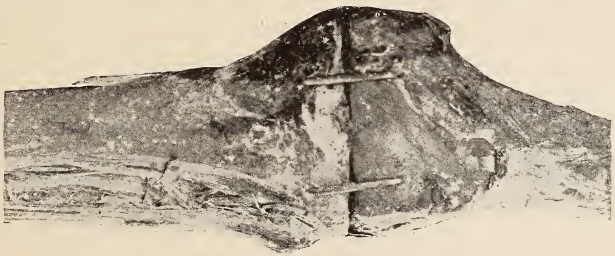




I.



II.



III.

In inserting the staples care must be taken to remove any interposing tissue. The staples are driven in with a light hammer or metal instrument until they lay snugly against the periosteum. The skin is sutured with interrupted silk worm sutures, and the leg is put up in a plaster cast at an angle of 100 degrees. When desirable a fenestrum can be cut out of the cast over the patellar region and the wound inspected. At the end of four weeks, or even sooner, passive motive can be made by cutting the splint and extending the leg, as already de-

scribed. I feel so thoroughly convinced of the practicability of this method and the ultimate results that I have decided to suggest it, even before I can prove my conclusions, hoping others may be induced to either try the suggestions offered or improve upon the methods now existing. A close examination with the X-ray of four cases, three of which were wired and one treated by the fixation method, proved that the methods were faulty. In one case only was there any bony union; that case was one in which I employed the modified cerclage method. In one, Barker's method was employed, and in the third I do not know, as the sutures had been removed. In the fourth the fragments were widely separated, though the function of the leg was good. I regret that the skiagraphs taken of these cases were too dim to be used, as they would have proven interesting if not valuable.

It was not until I had written the above and actually detailed the results of my experiments to the Orleans Parish Medical Society that my attention was called by Dr. Parham to the report of a case by Dr. Thomas Kittredge, of Salem, Mass. In this case Dr. Kittredge used almost identically the same method suggested by me in regard to riveting the bones. As this case is confirmatory of my own ideas, and I feel must add weight to the suggestion, I have made the following extract from the report, which can be found in the *Boston Medical and Surgical Journal* of November 19, 1891: "A man, aged 54 years, sustained a fall on a sidewalk, landing on his back and striking his knee. On examination a transverse fracture of the patella was discovered, which was treated with the figure-of-eight bandage, the leg being put up upon a ham splint. Union being apparent at the end of eight weeks, patient was discharged, but one month later he sustained a second fall, and after two weeks in bed returned to hospital with a four inch separation of the fragments, little inflammation and swelling being present. The following operation was then done: An incision being made from one condyle to the other, the joint was cleared of fluid, blood-clots and debris; the fractured surfaces of each fragment were sawed smooth, and the ragged edges of capsule trimmed. The joint was washed out with a 1–6000 bichloride solution. Surfaces of patella being brought into apposition and held, two holes, one

half an inch deep, were drilled on either side, three-eighths of an inch from line of fracture, and converging toward each other. Into these holes were placed galvanized wire rivets, their prongs being bent at right angles, but their points made to converge. Periosteum was brought down and stitched with cat gut, as was the capsule, the skin being sutured with wire. The wound was drained with rubber tubing and antiseptically dressed. Dressings were removed in six days, wound had healed by first intention, except holes containing tubes, which healed rapidly by granulation when they were removed. At end of eight weeks patient was allowed to walk on crutches. At the end of six months the joint is nearly normal in condition; little swelling or enlargement, surface of patella is smooth, line of fracture can not be felt, no movement of fragments, and movements of joint not interfered with; rivets are still in place." As improvements on above operation, Dr. Kittredge recommends use of copper or platinized silver wire, and instead of converging point of staples, their prongs might better be threaded, or their points clubbed, to prevent slipping.

I have since had the pleasure of corresponding with Dr. Kittredge on the subject, and he tells me that, though he had had necrosis in a few cases, a danger which we must expect from the use of any foreign substance, it has never been sufficient to prevent bony union. In these conditions, of course, the staples must be removed. This, however, is never necessary unless necrosis occurs. Since first writing on this subject I have discussed the subject freely with a number of my confrères, and by adopting some of the numerous suggestions made I find that the rivet can be more easily adjusted than I first believed and without even opening the joint. The method I would suggest if the joint be open would be, first to remove blood clots and trim off the ragged edges of the periosteum and prepatellar tissue, to adjust the fragments and hold them in perfect apposition with a pair of heavy, double-pronged vulsellum forceps, acting on the principle of the Malgaigne hooks. The staples are then put in position and driven into the bone without drilling. If it is not desired to open the joint the fragments should be brought together with the vulsellum, a long, straight needle inserted between the fractured ends, and lifted upwards, so as to remove

any interposing tissue. The fragments should then be properly adjusted and held firmly in position by the vulsellum forceps. A vertical incision, one inch in length, should be made, crossing the line of fracture at right angles, and over the center of the bone and through all the tissues to the periosteum. A retractor should be inserted and the line of incision pulled to one side and a staple driven in. This done the retractor is inserted from the opposite side and the second staple driven in in the same manner, from one-half to three-quarters of an inch apart. The skin incision is then closed with a few sutures. This procedure is certainly the simplest and attended with less risk than any I have seen suggested. Like myself, Dr. Kittredge informs me that he has experimented with these rivets on other bones, and has actually used them in several cases with the most satisfactory results. Wiring of bones with silver is unsatisfactory, as there is never any certainty of the wire holding, and lateral displacement is hard to overcome. In resections of the knee joint this is particularly the case, and I know no operation in which I believe these rivets would prove more satisfactory.

The cuts accompanying this article will fully illustrate the method.

MEASLES AND SMALL-POX IN CHILDREN.*

By E. M DUPAQUIER, M. D., New Orleans.

Gentlemen—Under the headings, which will appear, I have arranged in the synoptic table, presented here, the salient facts concerning 129 cases observed by myself, viz.: 128 cases of measles and 1 case of small pox, from September 6, 1899, to April 1, 1900.

I will read these facts and the commentary, as suggested from the field of action, the sick room. I hope that you will be interested, as I go along, and that you will be able to recollect some points which may lead to discussion, in other words, to more information on this subject.

---

*Read before the Louisiana State Medical Society April 20, 1900, as Chairman of the Section on Diseases of Childrer.

SYNOPTIC TABLE.

First Attack.	*Second Attack.*	*Age at which complications were more frequent.*	*Nature of Complications.*	*How was Antisepsis of the Mouth, Nose, Lungs and Skin Carried Out?*	*Was Balneation Resorted to?*	*Effects of Vaccination of Pregnant Women on Their Fetus as Regards Immunity to Vaccinia and to Variola.*
Measles, 123 cases. Small-pox, 1 case. *	Measles, 5 cases. Small-pox, none. Rötheln— Koplik's Spots Comparative immunity of sucklings. *	Under four years. Unfavorable prognosis. *	Rubeolic croup. Croupous pneumonia. Broncho-pneumonia. Pleurisy (acute). Enteritis. Scarlet fever. Nephritis (acute). Outbreak mild. Importance of measles. Public feeling of security is wrong. *	Mouth: boric acid and glycerin. Nasopharynx: camphor menthol in glymol-spray. Lungs: fumigations comp. tinct. of benzoin and creosote. Ipecac. *	Lukewarm baths for high temp. and agitation. Cold dip for delayed eruption. * Lukewarm baths during convalescence for removing desquamation in measles and scabs in small-pox.	Uncertain. Herviena's Report. Obstetrical Society's Report. *

First or Second Attack.—The rule is that "one attack regularly protects from subsequent ones." Out of 128 cases of measles, five were well authenticated second attacks; of these two were very intense, a period of about three years elapsing between the first and second attacks. Their first attack was not *rötheln*, which is characterized by almost complete absence of any constitutional symptoms (the eruption, usually, being the first symptom) and by swelling of the posterior cervical glands along the posterior border of the sterno-mastoid muscles. Speaking of differential diagnosis, I present here a very good plate from Tuttle's book, Diseases of Children, showing the pathognomic sign of measles, Koplik's spots, which appear on the first day of invasion upon the buccal and labial mucous membrane.

As regards small-pox, a number of second attacks are on record. My only case of small-pox, reported here, was a first attack, due chiefly to neglect of vaccination. It was a very confluent case.

Connected with this chapter of remarkably communicable or receptible contagium are a few remarks on the immunity of sucklings. Many in the laity and in the profession place, perhaps, too much confidence in their belief (unfounded) of the sucklings' immunity as regards contagious diseases. I must say that in house epidemics of measles, mumps and yellow fever I did see new-born (sucklings and bottle-fed) infants escape contagion. Yet I have seen, repeatedly, light infections, as coryzas and simple colds, transmitted from the wetnurse to her suckling, because of immediate proximity, I suppose. Indeed, the comparative and apparent immunity of sucklings to contagious diseases is due to the fact that they are comparatively isolated most of the time in their cribs, and that under four and five months they are not so often taken outdoors, rain or shine, as after the latter age. Unable to walk and play, sucklings and infants do not mix with others as older children do. Such is the view of Dr. Netter, of Paris, as regards measles; and, referring to *la grippe*, to which sucklings, as thought by many, were immunes, the same argument is offered by Dr. Ricaz, chief of the Children's Clinic of Bordeaux, in an able refutation, in *Annales de la Policlinique de Bordeaux*, February, 1900. As to comparative immunity of sucklings to small-pox within the first year in

times of epidemics, it is admitted. It may be accounted for by immunity transmitted in utero from the vaccination of pregnant women in epidemics, and, on this score, we may account for the record of only one-third of the deaths from small-pox among the new-born less than a year old.

AGE AT WHICH COMPLICATIONS WERE MORE FREQUENT.—Out of 129 cases reported, 22 cases, or 17 per cent., were complicated. Of these, 15, or 68 per cent., were under four years, and seven over four years. These figures concur with the admitted fact "that complications and sequelæ of measles are more frequent under four years." There is a practical object in fixing the age of danger in our minds, and that is to help us out in our prognosis; for, in practice, we have an irresistible desire to score a good mark, and any circumstance in favor of the patient, such as—chiefly—individual robustness and more than usual resistance, strongly tempts us to view rather the favorable issue of a bad case, notwithstanding the severe odds against the patient—such as age, and against the medical attendant—such as lack of proper nursing. I was caught overhopeful more than once, and do not depend any more on chances or uncommon individual resources to base my prognosis.

Under four years of age every child with measles is liable to have complications, and complicated cases of measles under that age are unfavorable.

NATURE OF COMPLICATIONS.—Out of 129 cases reported, I have had 22 cases with complications. The following were the cases:

Rubeolic croup, 1.

Bronchitis, leading to croupous pneumonia, 2.

Broncho-pneumonia, 14 (five deaths, 35 per cent.).

Acute pleurisy with effusion, 1.

Enteritis, 2 (two deaths).

Scarlet fever, 1

Nephritis (acute), 1.

I will read only the characteristics of these cases, and make as short a review as I can, omitting all remarks that have no immediate practical bearing.

Case of Rubeolic Croup.—White child, 6 years old. Marked laryngitis from the onset. On fifth day, typical attack of spasmodic croup. I grew anxious, thinking of membranous croup, a difficult diagnosis. Had told the family about intubation and

the calling in of a specialist. Later in the evening, after repeated vaporizations of calomel, under sheet-tent, profuse expected secretions brought relief. In town, the specialist is easily reached, but in country districts physicians should learn how to intubate, because measles, like diphtheria, may call for urgent intubation. Richardière and Balthazar, of Paris, in measles complicated with stenosis of the larynx or rubeolic croup, have performed intubation 36 times, up to their recent report, with 24 recoveries and 12 deaths. In these fatal cases, it must be said that autopsy revealed lesions of broncho-pneumonia and sub-glottic ulcerations. In several cases, the tube was left in the larynx but a few hours; in 20 cases, one single intubation was sufficient; in 12 cases two intubations were necessary; in 3 cases, where three intubations were necessary, patients died. In other words, in rubeolic croup, intubation should be tried *twice;* if not sufficient, instead of intubating a *third time*, perform tracheotomy.

Cases of Croupous Pneumonia.—White children, 3 years and 7 years, respectively, suffered after the subsidence of measles with continuous low fever and marked bronchitis. Both suddenly became very ill: vomiting, high fever, flushed cheeks, hot, dry skin, prostration, active nares, frequent respirations—about 20 respirations to 35 pulse beats.

"This perverted pulse respiration ratio," as Dr. J. Park West, of Bellaire, Ohio, says, in a very able artiele (See N. O. Med. and Surg. Journ., April, 1900, Dept. of General Medicine), "will often give us an early and may be the first clew to the disease, as it is one of the important signs; it points to the seat of the disease and occurs early, when distinctive signs are particularly needed."

By the way, I will remark that the same author, with reason, declares for the use of a binaural stethoscope, a capital point in practice, for detecting, in croupous pneumonia of children, the *small* diseased areas, these being located, not uncommonly, in the axillary spaces or at the apices. My final remark is that, *suddenly*, between two visits, a case left comparatively well with mild bronchitis may become very ill with croupous pneumonia. Luckily this secondary croupous pneumonia is just as little fatal as when primary; but the child becoming very severely ill on a sudden, people will seldom pardon the attendant for not posting them. We physicians must be born with considerable foresight.

Cases of Broncho-Pneumonia.—I will not stop to go into the details of this most common, varied, irregular and protracted disease in children; but I will say a word about *counter-irritation* in connection with broncho-pneumonia. I decidedly express my aversion to *blister* in broncho-pneumonia. Physicians differ as to this, and I beg to side with the opposition. I would be pleased to be persuaded that blistering *effectually assists us in such cases.* I much prefer as counter-irritants the applications of hot poultices, of concentrated iodin and of the cold pack.

Of course, when poultices are applied they must be properly and judiciously applied; in the back only, and not on the baby's chest, already yielding under an oppressive labored breathing, and they must not be kept there, either, to constantly macerate the skin. What a sight! Cyanosis, dyspnea, that painful expiratory grunt, heu! heu!—and a heavy poultice over it all! This is how a good thing is spoiled!

Applications of iodin allow us to better follow the shifting small areas of incomplete consolidation appearing everywhere, chiefly on the posterior regions of the lungs. Secondly, deposited upon the surface of the bronchial mucous membrane iodin exercises a beneficial influence upon the tissues and prevents decomposition of secretions.

For the typical paroxysms of dyspnea in broncho-pneumonia, everybody recognizes the efficiency of the cold pack, and I do not hesitate from personal experience to highly recommend it.

Case of Pleurisy.—White child, 3 years old. Had been discharged practically cured of his measles. Three weeks later was brought to my office with these symptoms, viz: Restless, chiefly at night, coughed, took no food, had lost flesh. Examination made me think there was some effusion on the pleura in the right side. Curiously enough the left side was bulging and everything was normal on the left side. It seems paradoxic, but it is a fact that many times in children the effusion is on the apparently smaller side (Marfan). I drew a syringeful of serous fluid with my hypodermic, but I did not aspirate. Absorption took place *spontaneously.* Child recovered.

Cases of Enteritis.—Two colored boys about 3 years at the Thomy Lafon Orphan Boys' Asylum, where I had, at one time, more than 15 children, from 2 to 12 years old, sick with measles. All that I knew in the tretment of infantile diarrhea,

seeking information from the best sources available, I have done and I failed. Both children died. It can not be doubted that in those fatal cases of diarrhea, following measles, at that age where treatment is comparatively easier than in infants, tubercular infection steps in, and, of course, carries the case beyond our aid and reach.

Case of Scarlet Fever.—Measles had been in the house of Mr. Jos. K., in my neighborhood, hardly a week when Anna, 11 years old, was taken sick together with a younger brother. Both had measles and nothing else as I thought. On the third day of eruption Anna became quite ill, vomiting, fever at a 105 deg. and severe sore throat. Her eruption now was of the typical tomato juice color all over; her tonsils were covered with pultaceous patches. The scarlatinal symptons predominated over the measles. She was immediately placed in a back room; in fact she had been isolated in her room already.

There had been no case of scarlet fever in the neighborhood, but the exposure took place at school, where some of her schoolmates had taken it. Three years ago Dr. Lejeune, a French army surgeon, brought out facts illustrating the opinion that the stage of contagion was the pre-eruptive stage in scarlet fever, and not so much or not only the desquamation stage. A young soldier returns to the barracks from a visit home just when his sister was taking to bed feeling very ill. The next day she had scarlet fever. A few days later the young soldier had a case himself at the barracks, and though he had been immediately isolated before the eruption appeared, that is, at the time of his taking sick (a strict rule in the army), other cases broke out in the barracks, which, though immediately isolated before the eruption's onset, had been infecting others besides. There was an epidemic, in other words, among the soldiers, the contagium being given apparently at the pre-eruptive stage. My case, here reported, had not been in contact with patients desquamating or relatives of patients desquamating, as far as I can affirm, but it is a fact that some of her schoolmates were taken sick a few days only before her. At any rate, attention must be given to desquamation, and it is now well recognized that daily bathing and soaping with sublimate soap, applying over the body glycerin 1 part, hydrogen peroxide 9 parts and 1 per cent. muriatic acid, will reduce in a

marked manner the duration of desquamation, and consequently the period of danger and of detention.

Case of Nephritis.—Little Thomas, colored, 2 years, is one of the fifteen cases of measles treated at the Thomy Lafon Orphan Boys' Asylum. A peculiarity about his measles was that during convalescence he was drowsy almost all the time, day and night. On repeated occasions I found him asleep in his small chair, and an unusually number of times he had gone asleep while eating. Shaking would arouse him, but he would soon drop back into his sleep. About one month after this the sister nurse brought him to my office; he was puffed from eyelids to toes, a typical case of anasarca, general dropsy.

Heart normal. Urine normal. *No albumin.* I am positive there was not a single case of scarlet fever in the asylum, and sure that little Thomas had not had scarlet fever. Ill-fed children, and such are children in some asylums, present general dropsy and ascites without albumin, though there are renal lesions, sometimes, it is true, just a simple epithelial desquamation is found on microscopic slides (Baginski). But such cases of nephritis without albumin exist (Cassel's cases), albumin is not detected as it is generally in nephritis of adults, because it is not examined often enough (Heubner). Repeated examinations gave me, at last, a trace of albumin with the potassium ferrocyanide and glacial acetic acid test. I recalled the drowsiness during convalescence, which indicated some uremic poisoning at the time, when it could not be accounted for. The case was treated with hot baths, according to Liebermeister's teaching, and strict milk diet. He made a good recovery.

The prognosis of non-scarlatinal nephritis or simple acute-nephritis in children is favorable, and the treatment limited to hardly any medication at all.

CASE OF SMALL-POX.—Referring to my case of small-pox, a white boy, 5 years old, I will say it was a very confluent case, but an uncomplicated one. He recovered.

REMARKS CONCLUDING CHAPTER ON COMPLICATIONS.—I do not know that this epidemic of measles was characterized by any peculiar complication, as epidemics usually are. Some complication, of course, prevailed; but not to the extent of making it the type of this "epidemic." I have not had abnormal cases,

the so-called "malignant" or "black measles;" and I was struck by the absence of convulsions either at the onset or at the acme of the eruption. I have not seen one case with convulsions, even in those children, who I knew were subject to them from birth. Yet, as mild as the epidemic was (7 fatalities out of 128 cases, about 5 per cent.), there was a good deal of surprise elicited on the part of the laity, and I may say, also, on the part of the profession, in particular as to the fact that *measles may be complicated by almost any other of the infectious diseases, one developing as the other subsides.*

The fact that measles was considered, for many medical generations in the past, as the open door to tuberculosis, is still alive in everybody's mind; the ready infection of the pulmonary apparatus in measles explains this axiom of old standing. The importance of measles is much greater than is commonly realized by the public. While typhoid fever and diptheria are a source of deep concern, the public seems to have no dread of measles. Yet Vallin has lately brought this subject before the Academy of Medicine of Paris, showing that in 1897 and 1898, for example, measles has caused 850 deaths, while typhoid and diphtheria caused about 250 deaths. He urged the authorities to enforce the report of cases of measles, and, also, the official disinfection as for other severe infectious diseases.

In September, 1899, when I met with my first case, I had very little assistance in families, as to the precautions I recommended, and rarely any attention as to my warning against complications. As time rolled on things changed. From November, 1899, in particular, measles began to be a topic of conversation, and some consideration was given to it. In January, everybody ran for the doctor and begged him to be very attentive, as severe cases had been heard of. This shows what the public had yet to learn regarding measles.

How was Antisepsis of the Mouth, Nose, Lungs and Skin Carried Out?—In both measles and small-pox antisepsis is indicated. In fact it is mostly all that we can do in uncomplicated cases. The condition of the skin and mucous membrane is already that of an infected field, even in the mildest cases, open to severe infection, and, as a preventive measure, cleanliness, if not exactly antisepsis, is of great value. In my practice I make

it a rule to have efficient antisepsis carried out in the simplest way.

For the mouth I order the nurse to smear the lips, gums and palate with boric acid five parts and glycerin thirty parts every two hours.

For the nose I order a glymol spray with a 1 to 2 per cent. camphor-menthol solution in glymol to be used every two hours.

For the lungs in measles, on an ordinary lamp with a small piece of heavy wire over the chimney I have a tea-cup placed half full of hot water with a teaspoonful of compound tincture of benzoin, to be kept simmering day and night, ordering ventilation of the room for half an hour, every two hours; or, if a small gas heater is at hand, I have a teaspoonful of creosote and water in a deep porcelain-lined plate, placed over the heater, to be kept simmering for two hours, three times a day.

Besides, in broncho-pneumonia, I empty the bronchial tubes, morning and evening, with a teaspoonful of a mixture containing 40 centigrams of powdered ipecac to 40 c. centimetres of syrup of ipecac. In small infants a few tablespoonfuls of lukewarm water with a little table salt produce the emetic effect looked for. This view of emptying the bronchial tubes by vomiting, as an antiseptic measure, belongs to Dr. Albert Robin, of Paris. He says it is the most reliable antiseptic for the lungs in bronchitis and broncho-pneumonia in the young and old; it is equivalent to the evacuation of the bowels as the surest of all intestinal antiseptics.

For the skin, in both diseases, I have the child cleaned all over twice a day with a sublimate soap and warm water, keeping the body smeared in the interval with sodium salicylate, 4 parts; cold cream, 100 parts.

WAS BALNEATION RESORTED TO?—The treatment of typhoid fever, in private practice, shows how, in general, balneation is ojected to, because it is troublesome and cumbersome, in cases of adults. But in cases of children, chiefly infants, it is more promptly accepted, because they are more easily managed. For my part, in serious circumstances I do not hesitate to squarely order bathing when I think it necessary ; and, in more than one instance, where opposition was warmly manifested, my insistance was made equivalent to my surrender of

the case. I knew, moreover, that my successor could not blame me.

In measles and small-pox, as in other infectious conditions, I believe that there is no better measure, chiefly, for abating restlessness and high temperature in children, than lukewarm bath, 98 deg. F. When the child rebels, as unfortunately occurs, it is most disappointing to have to resort to other means. Sponging is a good substitute; but it does not compare with the bath; irrigation of the bowels with cool water is much better than sponging, but it may cause collapse, more so than a lukewarm bath. I have used bathing, at the acme of the eruption, in four cases of measles having 105 deg. F. and great agitation with good results, followed by sleep; and, in one case of slow and delayed eruption with prostration, a rapid dip in cold water gave better results in a few hours than rubbing the whole body with vinegar and mustard.

Again, I have used lukewarm baths in the convalesence of my case of small-pox, every day, ordering a good soaking and rubbing with sublimate soap, and I find it to be very effective for removing the scabs promptly. The same method of bathing is recommended during the desquamation stage of measles; like in scarlet fever, it reduces the period of danger and of detention.

Effects of Vaccination of Pregnant Women on Their Fetus as Regards Immunity to Vaccinia and to Variola.—There may be other sources, unknown to me, than that from which I gathered information on this point; but I believe that the one presented here is worthy of consideration.

Three years ago, Herviena of Paris, before the Academy of Medicine, made an exhaustive report bearing on thousands of cases; and his conclusions were that vaccination of pregnant women does not protect their children, and the rule of not only vaccinating but revaccinating every new-born child in the maternity clinics, though the mother had been successfully vaccinated during pregnancy, still holds good.

Lately, in January, 1900, before the Society of Obstetrics of Paris, Drs. Bar, Béclère, Chambon, Ménard and Coulomb, after discussing the question, have come to the following conclusions (see *Gaz. hebd.*, No. 9, 1900):

1. The vaccination of pregnant women with reliable virus, even though performed during the last months of pregnancy, and, in spite of the number of successful inoculations on the same woman, does not ensure with certainty, each and every time, the intra-uterine transmission of immunity from mother to child.

2. The vaccination of pregnant women, when followed by intra-uterine transmission of immunity from mother to child, conveys immunity to the latter, only for a limited time, as the immunizing serums do, the period of immunity being by far shorter than that conferred by vaccination of the child itself.

3. To ensure lasting immunity to the new-born, vaccination of pregnant women is insufficient, unreliable.

4. Yet, during epidemics of small-pox, vaccination of pregnant women must be performed, for the benefit of both mother and child.

I believe that those who have made extensive vaccinations of pregnant women have reached similar conclusions.

For my part, I have successfully vaccinated only three pregnant women; and their new-born infants have been successfully vaccinated by myself at the very first attempt.

CONCLUSION.—Gentlemen, in dealing with children, we are dealing with precious lives. In fact, from the standpoint of the family, there is no dearer life, it seems, than that of the baby of the house; and its death, although quite natural from our medical point of view, is, not uncommonly, a source of accusations and hints directly aimed at either one, if not all three of the medical attendant's cardinal qualifications, viz: knowledge, attention and good-will.

While we are together, let us try to alleviate as much as possible the trials connected with our children practice by mutual information on such subjects as this; and, if, notwithstanding our best efforts, the inevitable will continue baffling our therapeutic skill, let us, at least, learn when to be firm in our prognosis; thus avoiding the bitter reproach of a disappointed mother: "But, Doctor, you told me my child would recover!"

These trials of the practitioner who has a liking for pediatrics, and is, heart and soul, in deep sympathy with children, may be

allayed by keeping well informed on pediatrics and by engaging in its practice, as Dr. John Thompson, the Edinburg authority writes it, "only after possessing a thorough grasp of the ordinary clinical methods."

Indeed, gentlemen, in treating sick children we are placed in a delicate position, for I need not say to physicians, to explain matters, more than this: children are the fruit of the crowning achievement of animal life, reproduction, and the expression of man's strongest feeling, love. May we be pardoned, when they die in our hands, after we have shown the mettle of competent physicians with tender hearts!

THE CARE AND TREATMENT OF THE INSANE.*

By Dr. G. A. B. HAYS,
Physician in Charge of the Louisiana State Insane Asylum, Jackson, La.

"The Care and Treatment of the Insane" is so broad and comprehensive a subject, covers so wide a range for thought, speculation and study, and is withal a subject of which so much remains unknown, despite the progress that has been made in recent years, that it is with much reluctance and some trepidation that I venture to approach it thus publicly, and address myself to men who have no doubt explored the vast accumulation of literature upon this theme, bathed in the seas of ink and traversed the mountains of paper that have been devoted to it. For centuries the question has been asked whether we can "minister to a mind diseased?" and before replying, the first query to one's self is, "what is the mind?" What is that subtle, intangible thing that we call "mind"? That portion of our being that masters and controls every other portion of our organism and holds them in complete and absolute dominion. We realize that it is of the nature of its twin sister, "soul," and absolutely beyond our ken in a material sense. We realize its vast importance and equally well its elusiveness when it takes its flight.

In the pursuit of a study of this nature there are greater difficulties to be met with than in any other branch of medical

* Read before the Louisiana State Medical Society at its meeting, April 19, 20 and 21, 1900, as Chairman of the Section on Mental Diseases.

science. In all physical diseases and injuries we have some point to start from, some basis upon which to rest the foundation of our treatment and to build thereon, but in mental alienation *per se* we have no such allies, no such support, as is afforded by the physical signs in usual medical and surgical cases.

Insanity is commonly defined as a "derangement or abnormal condition of the mental faculties, with or without loss of volition and of consciousness. Insanity may be due to defective development, to acquired disease, or to natural decay.

"It is characterized, according to its form, by a variety of symptoms, the most common of which are change of character and habits, moroseness, confusion, elation, melancholy, mania, delusions and hallucination."

Krafft-Ebing's divisions into two great groups, the one a "*disturbance* of the *developed* brain," the other "an *arrest* of *brain development*," is admittedly correct. But with all we are confronted with instances of mental derangement with diametrically opposite symptoms, moroseness and melancholy in one patient and elation and delusions of grandeur in another. Another with "circular insanity" will have his regularly recurring periods of mental exaltation, depression and sanity, to be followed by another cycle. I only mention this to demonstrate in a slight degree what difficulties are to be confronted and overcome in the "treatment" of the insane. We know the symptoms, but the cause of those symptoms is most usually beyond our reach.

Therefore we may never know what is the potent factor that is at work. There are so many varieties, and so much light and shade to be observed in madness that only an experienced authority can detect the insidious but sure approach of that malady which deprives one of nature's light and reason, and reduces him to the level of the beast which perisheth, when "That wretched brain gave way, and man became a wreck at random driven, without one glimpse of reason or of Heaven."

The *care* and *treatment* of the insane go hand in hand and are practically one, for the *care* is really the greater part of the treatment. As far as medication is concerned it is usually symptomatic. In certain cases where we have reason to believe the disease is due to some special or specific cause, as for instance,

syphilis, the drug habit and such like, the way is comparatively clear to a rational course of treatment. But as insanity is, as far as we know, judging from the manifestations, a deviation from the normal, every effort is to be bent towards a return to the normal. In my experience, the physical condition has always had to be attended to. Never was the truth of the axiom, "*mens sana in corpore sano,*" brought so near home to me as it has been since I have been connected with the insane asylum of the State of Louisiana. Notwithstanding the vaunted influence of mind over matter, we find that matter exerts a most powerful control over mind. Cleanliness is said to be next to godliness, and the latter is conceded to be the very acme of mind. The insane patient should be kept absolutely clean in person and surrounded by cleanly environments. As far as is consistent with safety, all appearance or evidence of restraint should be avoided. Kindness of manner and courtesy in speech should be cultivated and always shown to him. Uniform kindness and a judicious firmness are wonderful agents in gaining control over and the respect and esteem of your patient. Unfortunately, most people have an innate fear of the insane and no one is more quick to discover the fact than the patient himself, and he at once takes advantage of it. In that case one's influence for good is materially weakened, if not entirely lost. As far as possible treat the patient as though he was a sane, rational being. Give him exercise and occupation. That serves a double purpose: It gives him something else to think of apart from his real or imaginary wrongs, or grievances, or persecutions, and it assures him a good, quiet, natural portion at night of "nature's sweet restorer, balmy sleep." Insomnia is a frequent accompaniment of many forms of insanity, and when you have overcome that without resorting to drugs you have gained a great point and advanced a step in the right direction. Let him be entertained, amused, interested as far as possible. I cultivate some 300 or more acres of land entirely with patients. A great many of them take a lively personal interest in the results of this labor, in the growth of the crops, the progress of the vegetable garden, the condition of the stock, the number and quality of the hogs, just as sane people do. For those of literary tastes two reading rooms are provided for their especial use and they are furnished with an abundance of magazines and

periodicals of the day. The newspapers from nearly every section of the State are sent to us gratuitously by their editors and are read and discussed by the patients in a manner that would surprise the average person. They are interested in the war news, in politics, and in all the momentous happenings of the day. They make frequent excursions out in the country among the hills and the woods. The women return with great masses of wild flowers with which they decorate their halls and rooms. I have provided a seine for the men and often send them down to Thompson's creek, a mile away, where they enjoy the pleasures of a bath in a clear running stream and the sport of catching fish. They ride to the creek in wagons, are always successful, and on their return their fish is cooked for them and for their friends. On one occasion a local poet broke into verse with the following lines:

> "You need not bring your hooks and lines,
> So the experienced fishers claim;
> For all the fish in Thompson's creek
> Are sure to be 'in-seine.'"

Sometimes parties of patients drive as far as Fluker's lake, three or four miles distant, where fish and turtles are caught in the seine. Of course, they are always accompanied by their attendants, who take part in and enjoy their pleasures as much as do the patients. We have a ball at the asylum every week, which is a great source of enjoyment to a large number of them. A hundred or two take part in the dances, while others are satisfied to be lookers-on. We have an excellent orchestra of fifteen or twenty pieces, composed of the attendants, and it was organized expressly for the benefit of the patients. You may doubtless wonder why I mention these things, gentlemen, but this is all a very essential and important part of the treatment of the insane, and should never be overlooked or neglected. Use medicine when it is indicated and use it freely and promptly when necessary. Use restraint and authority when your judgment demands, but *always* judiciously. Get your patient to respect and esteem you, and above all to have confidence in you, and pursuing this method, or these methods rather, you will often find that restoration of the mental faculties will follow, apparently along the same unknown, mysterious route by which they had strayed away.

Each individual case has to be handled according to its individual merits, and, when success has crowned your efforts, you can justly feel that you have done more than him who has saved a human life, for I believe you will agree with me that death is preferable to hopeless insanity.

A FEW NOTES ON OBSCURE CASES OF SYPHILIS, WITH RELATION OF TWO CASES OF EXTRA-GENITAL CHANCRE.*

By L. G. LeBeuf, M. D., New Orleans.

This subject is one which belongs more to the domain of the specialist than to that of the general practitioner, but as it is to him that these cases are first brought, it is he who generally is called to make the primary diagnosis, it does not seem inappropriate to mention a few facts and observations which came under my notice lately, as I believe that we have more to learn from the difficulties and mistakes which surround obscure cases than the study or relation of absolutely typical cases. In general practice we are often led in errors of diagnosis, especially in cases of syphilis, because we are apt to accept too readily the subjective history of these cases. We accept the history they give, because we know them intimately, and generally believe the statements they make, and often fail to see conditions which would be very plain to the disinterested specialist. It is a very unfortunate mockery on the much vaunted civilization and progress of this great *fin de siècle* to think that this dreaded disease handed to us from the earliest times has gone on increasing at the frightful rate it has. In general practice we are often called to treat obstinate cases of rheumatism, unbearable headaches, conditions simulating paralysis and hemiplegia, and our entire pharmacopeia is brought into play, and still we do not succeed to give complete relief. If *en dépit de cause* we place those patients under an anti-syphilitic treatment, it works like a charm. Even though it may have been that in that very case we were unable to establish any kind of true history, no sign or recollection of a primary sore, no secondaries, no eruptions, no sore throat, no characteristic flush of fauces, no ulcer back

* Read before the Louisiana State Medical Society, April 19, 20, 21, 1900.

of tongue, no falling of hair, in fact, nothing to help the suspicion of the presence of the disease. If your patient understands what you are trying to establish by your questions he is most times highly indignant, and is deeply offended and rebels against such suspicions. The surgeon has a more clear field to travel, he deals more with tangible facts than the general practitioner. He has ocular proof that can not be denied. If he has too indolent an ulcer, a swollen, hardened knee, an exostosis, a gummatous deposit, an ununited fracture, a wound that will not heal, immediately he knows that he is dealing with something unusual and he can change his artillery.

Sometime ago a valued member of this society reported a most interesting case of gumma which was forcing the eye of a patient out of the orbit and which answered beautifully to antisyphilitic treatment in spite of an absolutely negative history of syphilis. To still more impress the profession with the importance of looking for the disease when apparently the history of cases were obscure he related the following: A well-known physician, living below Canal street, Nestor in the profession, had died recently, who for some years before his death had obtained more than an ordinary reputation; he was widely known for his success; for though not a man of special brilliancy, nor with any unusual medical education, still whenever any of the practitioners of his district became puzzled with any specially difficult case which did not happen to answer to regular technic, he would generally refer the case to this old physician. Invariably what appeared to be invulnerable in the hands of others always was cured by his treatment. So much so that at the end of his career when his span of life was nearly run, a younger physician, a man of considerable ability himself, asked him the cause of his wonderful success, telling him, now that his work was done, to bequeath to him the secret of his success. He very laconically answered that there was no secret, that his method was perfectly legitimate. All chronic and obstinate cases that did not answer to regular symptomatic treatment he invariably treated for syphilis, and almost invariably affected his case for good. Undoubtedly he was right, and when he did not strike the genuine condition he at least was able to affect para-syphilitic affections that so simulated syphilis that under treatment the results were the same.

Referring to some statistics furnished by the celebrated Prof. Alfred Fournier *a la Faculté de Médecine de Paris*, we find that in 1897 he had compiled a report of 10,000 chancres, the localization of which were: 93 per cent. on the genital organs; 0.67 per cent. peri-genital; 6.33 per cent. extra-genital.

In a further tableau of 642 cases of extra-genital chancres he localizes them in the following places: 434 cases were on the head; 4 cases were on the neck; 21 cases were on the trunk, *i. e.*, chest, abdomen and nates: 19 cases were on the breasts; 56 cases were on the upper extremities (this large number due no doubt to the frequent use of the fingers, especially in digital examinations by professional men;) 4 cases were on the lower extremities; 54 cases were on the anus and regions around the anus.

In this tableau, much the largest proportion of chancres of the head were on the lips, then next the tongue and the tonsils, for obvious reasons. The locality of least frequency was on the nose and the forehead. On the rest of the body, the trunk and upper and lower extremities showed a much smaller proportion. On the trunk of the body the greatest frequency of cases was on the breasts, undoubtedly from the contact with mucous patches from amorous syphilitics; on the hand and fingers of the upper extremities, on account of the frequent use of that member by physicians, accoucheurs and midwives (one in our midst was inoculated in that way.)

Of the localization of the anal and perineal chancres they are generally due to sodomy, *pédérastie*, the handling of the part by the unclean fingers and the dripping of secretions from the female vulva.

I regret that the extent of these few notes does not allow me to treat further on the etiology and the great diversity of description of extra-genital chancres, not only because of the medical interest in the subject, but because of the psychical aspect of the subject also. I merely wish to relate the experience I have had personally of a few cases, which though they presented some obscure features, answered generously to anti-syphilitic treatment, and to further impress the fact that we should not make *a priori* diagnoses, but always submit doubtful cases to therapeutic tests.

Case I. The first case I wish to relate is one of an adult male

about 30 years of age. He first came to me with three well marked chancroids on prepuce. He gave a positive history of non-intercourse for eight months previous to appearance of chancroids. He was a man whom I knew very well, and had no reason to doubt his statement. His previous history was perfectly free of any specific trouble. Under careful aseptic treatment instead of getting better, the chancroids increased in size and gave a peculiar hard indurated feeling to the fingers. Considerable phimosis taking place at that time, I decided to slit the skin back to the corona glandis to be able to treat the chancroids better. When I did so, I found a healthy space of flap, free of ulceration, so I circumcised him at this same sitting, all this under cocain anesthesia. The sensation of hardness and induration of this amputated flap made me think the case quite suspicious in character at the time of the operation. The line of incision healed slowly and suppurated in two places. Shortly after this, patient came back to me with marked nodules over the forehead, pains in his legs and back, and an eruption on chest, face and arms. I examined him again thoroughly and found the epitrochlear glands and the cervical glands enlarged, and the patient, with considerable tenderness on strong pressure over sternum. I immediately placed him under bichloride of mercury and iodide of potash, and all these symptoms disappeared in short order. As a further history of this case, I was able to find out that four or five months before preputial ulceration, patient had had a sore on his lip. He thought it was a fever blister, but it was thick and hard and was a long while healing, taking nearly two months, and being finally controlled only after using iodoform and aristol locally.

Case II. Is that of a physician who had been a very healthy man up to about six months before coming under observation. He had been married four years and had a child three years old in perfect health. He had had no sexual intercourse before his marriage for at least two years. He was a strong, robust man with no vices, with no history of special glandular enlargement, falling of heart, eruption or sore throat. About six months before the observation of this case began he had contracted a hypertrophic rhinitis from the inordinate use of formaldehyde disinfection in the service of the United States Marine Hospital. Crusts formed in his nose and he had the bad

habit of loosening them and pick them with his finger nails. When first seen he was referred to a nose specialist, who confirmed his own diagnosis of hypertrophic rhinitis, and treated the condition as a local one. An ulcer having formed on the septum, he found it necessary to burn this spot with the electrocautery. Shortly after this, owing to the absence of this specialist from the city, another specialist who saw the case at that time, considered that the ulceration was proceeding at an alarming rate. In less than three days it perforated the septum of the nose completely. Acid nitrate of mercury and orthoform were used locally, but without permanent benefit, for, though it seemed to arrest the disease temporarily, in one or two more days it had formed higher up perforating the septum in a second place and affecting even the upper turbinated bodies of one side. The whole nose seemed affected, the tissues became infiltrated, the upper lip swollen and red, and the case looked desperate and beyond control. After consulting two of the most prominent brother physicians of this city and recognizing the lack of other symptoms, in fact the absolute negative history of the case, still it was agreed to try a therapeutic test. Ungt. hydrargri, one drachm, was rubbed inside of each thigh and calf every night, and sixteen drops of a saturated solution of kalii iodidi taken internally for a whole week, and about inside of five days the disease was arrested, and in one month the fearful symptoms with the profuse discharge were entirely checked. The case went under treatment for the necessary length of time, without any return of the disease. In this case he had undoubtedly inoculated himself with his finger nails after treating some venereal case in his office and carelessly washing his hands. Consulting Fournier's tableau of cases, this case of chancre of the nose on the septum would make the sixth case on record.

Case III. Is one of unusual interest on account of the grave conditions following improper treatment and the obscurity of the history of primary trouble. It was that of a male adult—a bookkeeper by profession—aet. 36, patient excessively nervous, dyspeptic and often neurasthenic in his nervous manifestations. No decided history could be made of his case at first, except by the objective signs as they unrolled themselves to my view, little by little—enlarged glands, epithelial rash, later on severe

iritis, which an oculist confirmed to be of syphilitic origin, and other symptons. In spite of the gravity of these signs which were explained and impressed upon patient, he became very lax in his treatment, followed suggestions for about six months. After that time I was able to see him only every four or five months, and I soon realized that he was not over careful in his medication. He would stop for long periods at a time and then instead of three doses of his medicine a day, which made the full physiologic dose, he would take only one or two doses. This irregular treatment was kept up for nearly two years, until about two months ago he came back to me suffering considerably with a pain in the left side of his head. I prescribed for him but did not see him again for three weeks; when he came back to my office he was hardly able to walk, and when he attempted to shake hands his right hand fell listless to his side. The history he gave me then was that the medicine I had given him to relieve his head had not benefited him, so that on the recommendation of a druggist he began taking large doses of antikamnia. The night previous to his visit to my office he had gone out to a party of friends where he had drunk a little more than his habit; that night he was taken with most excruciating pains in the whole left side of head, such pains that it drove him nearly wild, to such an extent that he ran out of bed to the open garden in his night clothes, and when morning came he found himself paralyzed all on the right side. I made him go home and lay in bed at once, paralysis became complete inside of two days and though he had some sensation left he could not move leg or arm or hand, and when he raised his arm slightly he had no co-ordinated movement.

The diagnosis of the formation of a gummatous deposit making pressure on the left side of brain, was confirmed by the opinion of an able confrère, and we immediately began pushing his neglected anti-syphilitic treatment. He was still suffering intense pains in his head, was bed-ridden, and in a very serious condition. The same modus operandi was followed as in the preceding case, one drachm of ungt. hydrarg. rubbed in thigh, and 16 drops of the sol. of kalii iodidi was given internally, and small doses of sulphonal were administered to relieve pain and produce sleep. Paralysis was relieved in a week, and four weeks after treatment has been resumed, he has been able to

return to his work, that of a bookkeeper, which necessitates the use of his right hand exclusively. He is now under vigorous treatment and has at last realized the importance of it. Undoubtedly it is for such cases as these we must have our eyes open. Anyone can diagnosticate technical cases with well marked lines of symptoms, but it is the obscure cases deceiving us by a long array of strange symptoms and an irregular course that should be looked for, because if left alone they may do irreparable injury.

I do not believe that it has ever been claimed that syphilis runs a more rapid or insidious course because the primary sore is extra-genital; on the contrary, as the disease is becoming more and more disseminated it is considered the virulency of its manifestations are less severe, attenuated as it were by time, but it seems to me that any conditions like those just related are more difficult of handling because of the obscurity of the symptoms and the irregularity of their course.

Clinical Report.

A CASE OF ACETANALID HABIT.

By G. W. GAINES, M. D., Milliken's Bend, La.

Some four years ago, acetanalid was prescribed for a negro adult suffering from rheumatism. He found that he was relieved by its administration, but on leaving off the medicine for a few days the pain returned. So he began taking it constantly each day. Now he uses two ounces each week and has been doing this for some months. This appears remarkable, and as I have never seen in any literature mention made of the acetanalid habit, I wish to report this case.

Charity Hospital Notes.

(Specially reported for the JOURNAL.)

REMOVAL OF KELOIDS—LOCAL ANESTHESIA.

By DR. HERMANN B. GESSNER, Demonstrator on Operative Surgery, Medical Department, Tulane University, Etc., New Orleans.

We have before us a case of keloids of the inferior maxillary region in a negro male adult. As you know, keloids grow from cicatricial tissue—in fact, are generally regarded as a hypertrophied cicatrix. We rarely see these growths in the white, while they are very common in the negro. I undertake removal of these keloids, not that a recurrence is unexpected—it is a matter of record that recurrence after extirpation is the rule—but the patient being anxious to undergo operation, even if he be rid of the growth only temporarily, the procedure being simple and unattended with any degree of danger, I am thus afforded an opportunity to demonstrate the use of local anesthesia. There are three methods of applying local anesthetics: (1) Infiltration method, in which we inject directly into the tissue to be cut; (2) neural, in which we inject around or into a nerve trunk to secure anesthesia of the region of its distribution, and (3) intra-spinal, in which the spinal canal is injected to secure anesthesia of all structures beyond point of injection. The anesthetic used in this instance is the Schleich cocain solution No 1. There are three such solutions, containing the same constituents in the following proportions to the 100 minims of water: No. 1, cocain hydrochlorate, gr. 0.2, NaCl, gr. O. 2, morphin sulphate, gr. 0.025; No. 2, cocain hydrochlorate, gr. 0.1, NaCl, gr. 0.2, morphin sulphate, gr. 0.025; No. 3, cocain hydrochlorate, gr. 0.01, NaCl, gr. 0.2, morphin sulphate, gr. 0.005. We here have the choice of three solutions of varying strength, and by their application the danger of toxic effects is minimized. In using cocain as an anesthetic, never introduce more than 1 gr. into the economy where it will be absorbed—even three-fourths of a grain is regarded as a full dose. Recently eucain B. has been brought forward as a substitute for cocain. Its advantages over cocain are that it is three and one-

half times less toxic; it can be boiled and thus rendered aseptic; it can be kept in solution without deterioration; it is not so irritating, and being a synthetic preparation, it will probably become cheaper than cocain. For infiltration I see no advantage in it over cocain, solution of which may be readily made by using tablets prepared by all the large drug manufacturers; in the dilute solutions, much of which escape through the incision, it is practically without danger. Let me call your attention to the mode of infiltration in this case; we first pass the needle into the derm, not *below* it, and inject a drop of the No. 1 Schleich solution. This first injection should be the only painful part of the procedure, and even that may be done away with by first spraying the proposed point of injection with ethyl chloride. Having obtained a primary point of anesthesia, we may now, by keeping the needle point always within the zone of anesthesia, and enlarging that zone by injecting ahead of its path, complete the anesthesation of the field of operation. You now see that on removal of the growths with the scalpel we have not only *analgesia*, the condition commonly produced by cocain application, but also complete anesthesia, the patient not being aware of the completion of the removal.

Antiseptic as Well as Anesthetic.—What is claimed as a great advantage of nirvanin over cocain is the antiseptic property of the former. Professor Einhorn has shown that no putrefaction takes place in a 1 per cent. solution. Also, when various bacilli were sown in beef extract gelatin, containing various quantities of nirvanin, which was kept for two days at a temperature of 24 deg. C., no growth took place in the vessels that contained a 4, 3, and 2 per cent. nirvanin solution respectively.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

IMPROVEMENTS WITH NEW VOLUME.

With this number we inaugurate our fifty-third volume and enter the fifty-seventh year of our existence.

Ever anxious to progress and to increase our sphere of utility to readers and consequently to advertisers, we have added a "Department of Ophthalmology" under the charge of Drs. Bruns and Robin, both too well-known as the eye surgeons of the Eye, Ear, Nose and Throat Hospital and for their teaching in the New Orleans Polyclinic to need any introduction or commendation on our part.

We have also created a department of "Charity Hospital Notes," in which we shall regularly furnish interesting clinical data such as lectures, operations, and accounts of cases culled from the vast amount of material available at the 'Great Charity.' We have the promise of the hospital staff to aid us in making this new department useful to our readers and expect to see it develop into one of importance.

Also, while the details have not been settled upon, we have about consummated an arrangement with the Louisiana State Medical Society to furnish the Journal to each of its members and to give them space, monthly, in which to communicate news of interest specially to said members. This will add another department to our pages and increase our subscription list in quite handsome proportion, besides showing practical appreciation of our election as the official organ of the society.

THE LEPER HOME AND THE LEGISLATURE.

With a view to establishing more permanent quarters nearer New Orleans, the management of the Leper Home has petitioned the State Legislature for financial aid. The Home has now been in existence for almost six years, in which time very little has

been accomplished in the control of leprosy in the State. A portion of the lepers in the State have been housed; little or no attempt has been made to increase the number of inmates, and beyond the fact that an asylum has been provided for those afflicted with this disease, the Home has barely fulfilled the purpose for which it was originally created.

The present administration, judging from their biennial report recently published, propose to better conditions by making a site nearer New Orleans and accessible. The plan proposed aims at a system of colonization which is highly commendable. There has been, however, a lamentable oversight of provisions for the specific treatment of leprosy. When it is considered that elsewhere in the world the curability of leprosy is being tested with favorable results, there can be no excuse for the neglect on the part of the present management; a neglect self-confessed in the report referred to.

In this regard it is timely to bring into consideration the efforts of the Marine Hospital Service and the portent of the work projected by this department and the Federal government. Because of the frequently reported new focuses of leprous infection involving most of the States of the Union, the United States Congress has authorized an investigation of leprosy in the United States, and the Marine Hospital Service has been specifically empowered to this end. Already a special leprosy commission from the Marine Hospital Service has been organized and their work has begun with an attempt at collecting all data regarding the cases of leprosy in this country, with regard to locality, infection, nativity, migration, etc. The ultimate object of this investigation seems to point to a national provision for these cases, and probably at no distant date. This seems to be the natural solution of the question as the segregation under the best of medical and other care at the cost of the government is the only way in which a voluntary isolation of these cases may be accomplished. If the purposes of the United States Marine Hospital Service are attained, the Louisiana Leper Home must fulfill only a temporary need at best, while the methods of segregation and the opportunities afforded must be much improved over those at present in existence, if the Louisiana home is to be made permanent and independent of Federal control. We are as loath as others to descant upon

the condition of leprous infection in Louisiana, but when it is considered that in the United States, Louisiana is alone in having an endemic disease constantly and rapidly on the increase, the question of the control is more serious than is generally conceded.

If Louisiana is bent upon providing for its lepers for all time, then it is now more than urgent that ample provision should be made by the Legislature, not for a temporary sum of money, but enough to equip not only a "Home" or an asylum, but with provisions for hospital facilities where those sentenced to isolation may have adequate care in a medical way, while creature comfort is not overlooked. From the reports made in recent years, Louisiana has probably more than five hundred lepers in her confines, of which the thirty-one now isolated is a very small part.

If the Legislature does not see fit to establish a leper home and hospital on these lines, then the scheme of legislation should be changed so as to put Louisiana in a position ready to meet the National Government, when that government turns our way. Abolish the home if it can not be a credit to the State; do away with a State Board of Control; create a commission on leprosy to investigate the actual occurrence of the disease; record the cases and when a national hospital for lepers eventuates, give the proper authorities the necessary power to see that every case is urged to go or is sent to such an asylum.

The question is too vital in Louisiana to be shifted about. Either the home is an entity, ready and equipped to do what should be done, or it ought not to exist.

ILLEGAL COMPOUNDING OF PRESCRIPTIONS.

In an interesting letter of recent date, Dr. E. H. Smith, of Planchette, La., calls our attention to the twin evil of counter-prescribing and of illegal compounding of prescriptions.

The former is probably as prevalent in New Orleans as it is anywhere, while the latter thrives more in the country parishes, but both are too general and should be stopped.

A united effort on the part of the reputable medical and pharmaceutic professions respectively could arrest the evil. If the

druggists discontinued the counter prescribing, they could better expect the aid of physicians in putting a stop to illegal compounding.

As always, it is the general public which is most apt to suffer by the wrongs referred to and which should try to right them, yet the allied professions owe to that public their assistance in the matter through their organized representatives in the State Board of Medical Examiners and the Board of Pharmacy.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

A New and Simple Method of Sterilizing Catgut.—Elsberg, of New York, describes in the *Centralblatt für Chirurgie* of May 26, what seems to be a very efficient and certainly a simple procedure for sterilizing catgut. If it turns out to be as reliable as Elsberg says it is, it will undoubtedly be a very valuable addition to our surgical resources, since the method is so simple as to be within the reach of all.

After briefly mentioning the methods suggested by Lister, von Bergmann, Braatz, Martin, Kocker, Macewen, Reverdin, Lauenstein, Krönig, Brunner, Dowd, Fowler, Saul and Hofmeister and stating the objections that may be urged to them, he describes his own method, which he believes in simplicity and reliability superior to them all.

The method is founded on the chemical principle, that organic substances are insoluble in fluids by which they are precipitated. Thus, egg albumin is precipitated out of its solution by sulphate of ammonium; therefore, albumin is insoluble in concentrated solutions of sulphate of ammonium. This peculiarity of sulphate of ammonium is the basis of the method which Elsberg now proposes.

Raw catgut is deprived of fat by letting it lie twenty-four to

forty-eight hours in a mixture of one part of chloroform and two parts of ether. The gut is then rolled in a single layer on glass spools or tubes. A solution of ammonium sulphate is prepared by adding the salt to boiling water up to saturation. The catgut is placed in this solution and boiled for from ten to thirty minutes, then taken out and shaken up for half to one minute in warm sterile water, carbolic or sublimate solution to wash out the salt. It is now ready for immediate use, or it may be preserved in strong alcohol.

Elsberg asserts that in this manipulation the gut parts with none of its physical characteristics, strong gut losing none of its strength and thin gut seeming actually to gain in tensile strength. It does not swell and remains soft and pliable. In human tissues it is absorbed in from four to eight days. Bacteriologic investigations show that uniformly this gut after five minutes boiling is sterile. A table is appended to show the sterility of the material.

In place of water as the menstruum for the ammonium salt, 2 per cent. carbolic or 1-10 to 1-2 per cent. chromic acid solution may be employed. In the carbolic solution the disinfection is more quickly accomplished.

The solutions of ammonium sulphate may be used again and again, since the ammonium salt, which recrystallizes out of the cold solution, merely requires heat to bring it again into solution, and is in no way injured by the boiling process. The gut itself may be boiled three to six times for fifteen minutes without being changed. Should the author's claims be fully verified by the experience of surgeons, Elsberg will have discovered a method which will commend itself as the *ne plus ultra* of simplicity. No expensive apparatus and no complicated manipulation will be required, so that any surgeon or any hospital can on short notice prepare all the reliable catgut that may be needed. The difficulty of preparing it and its cost being so much reduced, there will be no longer any excuse for using unabsorbable material for any purpose for which catgut may safely be used.*

Cervical Aerocelē.—Mr. Guinard (in *Revue de Chirurgie*, May 10, 1900), relates the case of a woman, aged 32 years, who,

*Sulphate of ammonium is quoted in Merck's list at 39 cents a pound for the chemically pure; this would be about 50 cents a pound at retail.

in usual good health and unaccustomed to any effort, was seized, two years previous, during an attack of migrain, with violent spells of vomiting.

Whilst straining to vomit she felt some crackling in her neck, where, in a few days, she noticed a small lump. The swelling remained the size of a small egg for 18 months; but for the past 6 months it is progressively enlarging.

When Mr. Guinard first saw the lump it was as large as a mandarin orange, and located in the right supra-clavicular triangle.

The skin is normal and non-adherent to the tumor, which seems to spring from the depth between the trapezius and sterno-mastoid. On percussion the tumor was found to be sonorous in its upper two-thirds and flat in its lower third. Reduction could not be made by pressure.

Mr. Guinard extirpated the tumor on the 29th of December, 1899. The sac, being very thin, was ruptured during the operation, gas noisily escaping, followed by a clear, yellow fluid.

The sac was, however, easily removed in toto; a delicate, fibrous band directed towards the larynx united it to the depth.

The histologic examination of the pouch, made by Mr. Gombault, revealed its structure to be composed of a derm, covered over by one layer of epithelial cells; there were no ciliated cells.

In discussing the pathology, Mr. Guinard admits the violent effort as the exciting cause of the gaseous tumor, but the predisposing cause which is generally acknowledged to be due to the tracheal walls being weakened by pre-existing disease or congenital predisposition was absent. The distance between the tumor and the trachea, and its non-communication with the air passage, would exclude the idea of congenital anatomic predispositon.

Mr. Guinard is disposed to classify his case with those of pneumothorax, caused by violent efforts, and well known to physicians.

Under the strain the trachea yielded possibly; then air, instead of being absorbed, remained encysted.

Mr. Guinard considers complete extirpation the radical treatment of cervical aërocele.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans, La.

The Systematic Treatment of Eclampsia by Chloroform and Chloral.—That the systematic treatment of eclampsia by chloroform and chloral is undergoing a change is quite evident after a perusal of an editorial in *Obstetrics* for April, 1900. Attention is called to the various forms of treatment advised for the condition which are necessarily the outcome of the numerous conflicting ideas as to etiology and pathology. Perhaps, after all, says the writer, "the practical obstetrician need not feel that he is worthy of too great reproach for his inability to find a satisfactory treatment for a condition whose everyday phenomena are unsolved riddles to the physiologist and pathologist." When laboratory scholars have agreed upon a theory as to the origin and life history of urea, perhaps the solution of this perplexing condition will follow. Modern authorities are beginning to agree that the prolonged chloral and chloroform narcosis is too much in vogue, and unfortunately very dangerous.

Ohlshausen and Veit, in the last editions of their work, while strongly advocating the use of morphin, and not advising the use either of chloroform or ether (except in operative procedures), admit the superior safety of ether.

Ahlfeldt unites with them in proclaiming the danger of prolonged chloroform narcosis.

Smyly of the Rotunda Hospital, after many years' observation, admits that it increases the tendency to death. Fritsch states, also, that many deaths have been caused by this kind of treatment which might otherwise have been avoided.

Anesthesia in the various obstetric operations is indispensable, but its long continued use simply for the purpose of suppressing the convulsions, is a source of danger to both mother and child.

Dührssen has called attention to the occasional occurrence of death at the very beginning of chloroform narcosis in cases of eclampsia with much uterine distension.

The writer suggests that in such cases it would seem a wise precaution to rupture the membranes before beginning the anesthetic.

The Treatment of Tumors Complicating Pregnancy.—Brooks H. Wells has contributed to the *Medical News* a most interesting and practical article on this subject. The all important subject of cancer as a complication is reviewed thoroughly. Impregnation frequently occurs in the presence of cancer, and two-thirds of the cases go on toward term. The increased circulation and succulence of the tissues, incident to pregnancy, is a stimulus to cancer growth, which causes it to spread with extreme luxuriance, and the cachexia increases rapidly. In some cases, the women die before term from exhaustion, or from septic infection from the breaking down cancer tissue—an infection which may be the result of bruising incident to even repeated digital examinations. If abortion occurs, there is increased risk from sepsis and hemorrhage. Over thirty (30) per cent. succumb when delivery occurs spontaneously at term, many from rupture of the uterus. About fifty per cent. die where the aid of forceps or version or craniotony has increased the traumatism and subsequent exhaustion, hemorrhage, sepsis and sloughing. Nearly all of the children are of feeble vitality, and about forty per cent. are born dead.

It is usually impossible to be certain that pregnancy exists before the end of three months if cancer is present. In such cases, the child should be entirely ignored, for the operative indication is even more urgent than in the unimpregnated condition. The uterus, while yet small, together with the upper portion of the vagina, should be removed by vaginal hysterectomy or Werder's operation. With favorable conditions, the vaginal operation is best.

If the disease is advanced or the body of the uterus is larger, Werder's method is advised. This consists of tying the ovarian and uterine arteries through an abdominal incision, and freeing the uterus from the bladder and broad ligament without opening the vaginal vault. The vagina is then freed from attachments by blunt dissection as far down as is thought advisable Then the uterus is drawn down and out through the vulva by stout traction forceps attached to the cervix, the peritoneum united over the fundus, the abdomen closed and the operation

completed by removing the uterus after dividing the inverted vagina at the point selected. Supra vaginal amputation of the body of the uterus is advised if it is found too large to pass easily through the vagina. During the fourth and fifth months combined hysterotomy is still the procedure of choice. During and after the sixth month, however, the viability of the child is to be considered. If the child is viable, induced labor and hysterectomy or Cesarean section is indicated. If the cancer is not recognized until the time for labor has arrived, its diagnosis, if it is not far advanced, may be difficult. Dilatation of the os as labor advances is not prevented in such cases, but deep tears are prone to occur. If dilatation is not possible and the cancer is confined to one lip the tissues may be scraped away and deep incisions together with rupture of the membranes instituted. Where the tissues are extensively involved Cesarean section and immediate removal of the uterus and vagina is indicated. Craniotomy on the living child is positively unjustifiable, as the mother is doomed; furthermore the manipulations incident to crushing the child may hasten the woman's death. Where cancer affects vulva, vagina, or rectum, remove the masses if small and deliver per vaginam, but if the disease is advanced the abdominal incision gives the best results. Barton Cooke Hirst (Text Book of Obstetrics) states that cancer of the cervix will interrupt gestation at various stages, but in a certain percentage (sixty-six according to Müller) the pregnancy goes to term.

If the disease is not too far advanced; if it is confined to one lip of the cervix, and that the anterior; and if there is not too much cicatricial infiltration around its periphery and up the cervical walls, the labor may be terminated spontaneously, but this is rather the exception. He also favors Cesarean section as the proper treatment for labor obstructed by cervical cancer. The woman's life is surely doomed in the near future, and the child at any rate should be saved, even at considerable risk to the mother. If the woman is likely to die before the natural end of pregnancy, owing to the rapid progress of the disease, Hirst states that it may be desirable to operate before the fetus reaches maturity.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Appendicular Pleurisy.—Prof. Dieulafoy read before the Academy of Medicine of Paris a paper on appendicular pleurisy, of which the conclusions are summarized here.

1°. Appendicular pleurisy is the infection of the pleura following appendicitis. Infection, as a result of appendicitis, takes place in the pleura just as it does in the liver, differing in that it spreads in the case of the liver through its gateway, the portal vein, while in the case of the pleura it is propagated by the help of adhesions and the lymphatics.

2°. Appendicular pleurisy is met with chiefly in cases of ascending appendicitis. The aërobion and anerobion infection from the appendix rises again behind the cecum and colon, stretching by degrees, sowing on its way up from place to place, pus, membranes, adhesions, and at times, encysted collections. The infectious products bedeck the liver and spread on the inferior surface of the diaphragm under the form of subphrenic abscess.

3°. Sometimes the infectious agents produce perforation of the diaphragm, sometimes they penetrate into the thoracic cavity by the help of the lymph-wells without the diaphragm being perforated.

4° The appearance of appendicular pleurisy comes on a few days after the onset of appendicitis. Indeed, the symptoms of appendicitis seem to quiet down when the pleural complication arises. In six, eight or ten days infection has had time to travel from the appendix and reach the pleura.

5°. Appendicular pleurisy is always on the right side. Exceptions to this rule are extremely rare. The pleuritic stage is blended with the hepato-phrenic stage. Sharp pains in the right hypochondriac region, thoracic pain extending to the right shoulder, fits of coughing without expectoration, intense dyspnea, such are the signs of the onset.

6°. In some cases, the pleural infection is, so to say, hardly outlined, and the lesions dwindle to a dry pleurisy manifested

only by a grazing friction sound. At times, also, the liquid effusion is simply serous, hardly, if at all, infectious, and the complication passes off in an uneventful manner.

7°. But, usually, the liquid effusion is cloudy, fetid and putrid, heterogenous, giving off rapidly a precipitate. Signs of an abundant liquid effusion are easily made out and there appear, in addition, signs of pneumo-thorax due to gas arising from the putrefaction process. In one case there happened a vomica (as understood by the French, a sudden and profuse expectoration of a fetid and purulent liquid).

8°. The prognosis in appendicular pleurisy is of a most serious character; the constitutional symptoms, the condition of the pulse and the rapid debilitation of the patient are all indicative of its gravity.

9°. Confronted by a fetid and putrid pleurisy on the right side, one must always think of appendicitis and inquire about abdominal symptoms that might have preceded the present phrenico-pleuritic illness, from six to ten days prior, thus connecting the links in the history of the case.

10°. Surgical intervention must be promptly determined upon; at times its scope must be two-fold, viz: Empyema operation for the pleural and laparotomy for the abdominal infection.

11°. Notwithstanding this double intervention, it is to be feared that the patient may succumb, for he is at that time deeply infected. Consequently the unquestionable treatment is prophylactic, that which consists in removing the appendicular focus as soon as appendicitis is diagnosed. This is the only wise and rational therapeutic measure which gives security against the numberless dangers and complications of appendicitis.—*Bull. de l'Académie de Médecine—La Revue Médicale*, Montreal, May 16, 1900).

Oxyuris in the Appendix of Children.—A boy of about 8 years was recently operated upon for catarrhal appendicitis at the Presbyterian Hospital, in New York, and sections of the organ showed several specimens of oxyuris in the lumen. The question as to the frequency of the condition being thus raised, a search of the literature was made, and it was found that, so far from being rare, the presence of oxyuris in the cecum and appendix is the rule if the child be affected at all. An exhaus-

tive account is given by G. F. Still (*British Medical Journal*, April, 1900). He reports that out of thirty-two autopsies upon children showing oxyuris in the colon, the parasite was found twenty-five times in the appendix also. He suggests very plausibly that the apparent resistance of the affection to the ordinary drugs is perhaps attributable to this very fact, the appendix serving as a focus and breeding place for new crops of eggs and worms however completely the colon be irrigated with parasiticide solutions. For a cure he proposes that along with the classic procedure of injecting salt solution or quassia infusion (a pint and more in children of 6 to 12 years), santonin should be given (in safe doses) by the mouth, and the treatment carefully persevered in as long as needful.—*Pediatrics*, May, 1900.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Largin is the latest and in some respects the best of the synthetic silver compounds. It is stated by Merck to contain 11.10 per cent. of silver, combined with protalbin. It is, accordingly, richer in the percentage of metal than any of the other compounds. It occurs in the form of a stone-colored rather granular powder, soluble in hot water. Its solutions are precipitated neither by albumin nor by chlorides, so that it is likely to penetrate in active form more or less deeply into the tissues of the conjunctiva. So far, largin has been used by few ophthalmic surgeons. In fact, Welander, Falta, Pretori, and Stephenson appear to be the only ones who have investigated the action of largin in eye diseases. Welander employed it successfully in gonococcal ophthalmia, while Falta reported surprising results in conjunctivitis, keratitis, and in affections of the tear-passages.

"In acute blepharo-conjunctivitis, often the result of infection by pus organisms, largin renders good service, applied both as a 5 per cent. ointment and a 10 per cent. lotion."—Sydney Stephenson in *The Therapist*.

LEVURINE.—In the *Scottish Medical and Surgical Journal* for April, Professor Simpson, of Edinburg University, reports some favorable experiences with levurine, which is the name given to a dried extract of beer yeast (*levures de bière*) "so prepared that we have it concentrated in powder form, always fresh, constant in action, and in an easily administrable form. It may be taken in beer or aërated water, or to those for whom the taste is too repugnant, in cachets. The dose is a teaspoonful, to be given before food, three times a day, if necessary, until the desired effect is attained of arrest of suppuration and reduction of temperature. Whether the levurine produces its effect by counteracting, as Casset and Beylot had suggested, a latent glycemia, or by acting as a germicide to streptococci and staphylococci, or as an antagonist to their toxins, or in whatever way it works, the results of its administration in the cases I have noted are so striking that I have thought it worth while to bring it thus under your observation." The cases mentioned by Professor Simpson are those of high temperature following septic infection. He also reports a case by Dr. Buce, where levurine seemed beneficial in the treatment of a case of carbuncle.—*The Therapist.*

BASICIN.—Dr. Kreidmann, of Altona, writes: "Since 1883 I have tried to combine quinin with free caffein, and I have succeeded in preparing from these two substances a compound which serves as a base for a large number of combinations with the acutely acting alkaloids, at the same time possessing an almost unlimited solubility in ordinary water (without any addition). This product is called by me 'basicin;' it contains about two parts of quinin and one part of free caffein. The solutions in ordinary water, *e. g.*, 1 in 1, keep for a long time at room temperature (15 to 18 deg. C.) without either crystallizing or decomposing. They are of a yellowish appearance, and are incompatible with alkalies, acids or carbolic acid. Of the acutely acting alkaloids, such as atropin, scopolamin, hyoscyamin, pilocarpin, eserin and strychnin, basicin solution can contain such quantities as can be permitted for therapeutic purposes."—*Ibid.*

THE PHARMACOLOGY OF CANNABIS INDICA.—After describing certain experiments made by him, Dixon reports to the *British*

Medical Journal of November 11, 1899, the following conclusions:

Hemp exerts its effect differently according to the preparation used, fresh hemp, for example, being diuretic, whilst the dried possesses little such action. Its effects vary according to the manner in which it is taken into the system; when smoked exhilaration is most manifest, whilst when taken by the mouth in small quantities exhilaration is generally not observed.

In cases where an immediate effect is desired the drug should be smoked, the fumes being drawn through water. In fits of depression, mental fatigue, nervous headache, and exhaustion, a few inhalations produce an almost immediate effect, the sense of depression, headache, and feeling of fatigue disappear and the subject is enabled to continue his work, feeling refreshed and soothed. Dixon is further convinced that its results are marvelous in giving staying power and altering the feelings of muscular fatigue which follow hard physical labor. When given by the mouth one or two hours are necessary before absorption occurs, the effects produced being more lasting than when it is inhaled. Hemp taken as an inhalation may be placed in the same category as coffee, tea and kola. It is not dangerous and its effects are never alarming, and Dixon has come to regard it in this form as a useful and refreshing stimulant and food accessory, and one whose use does not lead to a habit which grows upon its votary.

By the mouth, on the contrary, hemp should rather be classified with the narcotics, and when given in this way the nervous effects produced may be such as to cause serious alarm, yet no danger is to be apprehended whilst the heart remains regular and strong. It is to be feared, however, that cannabis indica can never become popular until its active principle has been isolated—that is, the isolation of a compound of fixed strength. Like any other stimulant or sedative narcotic, hemp may be abused, as when taken to produce an intoxicant or deliriant effect, but this abuse is rare, and there is reason to believe has been grossly exaggerated.

Finally, from a frequent observation of hemp, both subjective and objective, Dixon can affirm that it is soothing and stimulating, being, when inhaled, a specially valuable cerebral stimulant.

He believes it to be an exceedingly useful therapeutic agent,

one not likely to lead to abuse, and producing in proper dosage no untoward after effects.—*The Therapeutic Gazette.*

Anesthesia of the Skin by the Use of an Electric Current.—Gonka (*Centralblatt für Chirurgie*, No 4, 1900) has endeavored to anesthetize the unbroken skin by the use of cocain solution and the galvanic current. A wad of cotton was saturated in a 4 per cent. solution of cocain placed upon the surface, which it was desired to affect, and over this was placed the positive electrode of the battery, the negative electrode being applied to any other portion. The amount of anesthesia accomplished depends upon the strength of cocain used and the amount of current. A current of ten milliampères continued for ten minutes, enabled the operator to drive a needle through the skin without causing any pain; nor could the burning of a hot glass rod be perceived. Anesthesia did not last longer than five minutes.—*The Therapeutic Gazette.*

Urinary Antiseptics.—Sluyts (*Centralblatt für Chirurgie*, No. 4, 1900), as a result of an experimental research with the ordinary pathogenic microbes found in the urine, finds that salol is distinctly the most effective drug we possesss in inhibiting or destroying these growths; Grosglik, after an extensive experience with urotropin, states that this medicament does not destroy the microbes found in the urine, and that even its inhibiting action is comparatively slight and of brief duration; hence it is of distinctly less potency than salol or sodium salicylate. He notes that the infectious diseases of the urinary tract are not beneficially influenced by urotropin.—*Ibid.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King, New Orleans.

Secondary Hemorrhage Following the Use of the Suprarenal Extract in Intra-nasal Surgery.—Suprarenal extract has of late come to play a very important role in the surgery of the mucous membranes, particularly in the nose and throat, and

although its great value as a hemostatic is generally recognized and its virtues freely extolled by many who have had experience with the drug, the reactionary sentiment is beginning to show itself, and some of its disadvantages become the subject of discussion. In this vein Dr. F. E. Hopkins, of Springfield, Mass., read a paper before the meeting of the New York Academy of Medicine, February 28, 1900, in which he brings out a well supported claim that secondary hemorrhage is a frequent occurrence after the use of suprarenal extract in nasal surgery. He had also observed that an idiosyncrasy existed in certain persons and that violent rhinitis and symptoms of intra-nasal irritation resulted from its use in these cases. Investigation of the subject among those who had made use of the agent extensively brought to light the fact there was an increased tendency to hemorrhage occurring within two or three hours after operation in cases in which the use of cocain had been combined with the use of the suprarenal extract than when cocain alone was used. The author reported two cases where alarming hemorrhage followed its use. He found it, however, a most valuable agent in the treatment of acute and subacute inflammations of the upper air passages, and during operations where it was important to keep the field clear of blood.

In the discussion that followed the reading of this interesting paper a number of important facts were brought out in regard to this drug. Several cases were mentioned where more or less hemorrhage had been observed coming on within a few hours after its use, and in some the irritative effect was experienced; this latter, however, was ascribed to the use of impure solution of the drug. Being an organic substance it readily undergoes decomposition, and when applied to a raw surface may give rise to infection. In solution it should be combined with some antiseptic, such as resorcin, 1 per cent. (Coakley), boric acid, alcohol or hot camphor water (McKernon).—*Laryngoscope*, April, 1900.

The Use of Formaldehyd in Rhinology.—H. Braat, of Arnheim, has found formaldehyd a useful agent in the treatment of certain affections of the nose and throat. In fourteen cases of maxillary sinus suppuration he obtained very favorable results by daily lavage of the cavity with a 1 per cent. solution of formaldehyd. In the treatment of ethmoidal suppuration

also the results were good. For suppurative otitis it is best combined with cocain on account of the pain it causes when applied within the ear. In the nose it should be applied carefully on a cotton-mounted applicator. If used as a douche for the nose enough might be swallowed to give rise to toxic symptoms.—Report of the Netherland Laryngological Society, *Monatschr. Ohrenheilkunde*, Sept. 1899.

The Treatment of Catarrhal Deafness with Pilocarpin.—Fischenich, of Weisbaden, strongly recommends the use of pilocarpin in cases of deafness due to middle ear catarrh, whether or not there may exist complications of the labyrinth. During four years he has treated 120 patients by this means, and with favorable results. His method consists in injecting a 2 per cent. solution of pilocarpin directly into the tympanum by the Eustacian tube, the number of injections varying from thirty to forty, according to the amount of deafness and the duration of the disease. He claims that an improvement is noticeable in the hearing soon after the treatment is begun, and that the improvement continues even after the treatment is left off, showing, as it were, a cumulative action of the pilocarpin.—Report of the Sixth International Congress of Otology, *Revue Hebdomadaire de Laryngol., d'Otologie*, etc., Feb. 24, 1900.

The Radical Treatment of Acute Follicular Tonsillitis.—Dr. M. A. Goldstein, of St. Louis, in the April number of the *Laryngoscope*, describes his method of treating cases of this nature by radical means, which is as follows: With a small spoon curette specially adapted for introducing into the tonsillar crypts, he thoroughly scrapes out the contents of the diseased follicles, attacking each one in turn. This done the cleansed follicles are touched with pure guaiacol introduced by means of a cotton mounted applicator, care being taken to apply it thoroughly within the follicles without spreading the medication over the surface of the tonsil. A saturated solution of trichloracetic acid, Loeffler's solution, or a ten per cent. solution of protargol may be used in the same manner. Two or three applications at intervals of eight hours usually suffice to effect a cure when the case is seen early. A gargle consisting of one drachm of liquor ferri chloridi to one ounce of

glycerin, a teaspoonful in a glassful of water to be used every two hours, completes the local treatment. In additon to this the author recommends the administration of a brisk saline purge, sweating freely with pilocarpin, and a thorough saturation of the system with sodium benzoate and sodium salicylate.

Nirvanin, Its Employment in Rhinology, Laryngology and Otology.—Dr. Mignon, of Nice, has made some careful clinical observations on the use of this agent as a local anesthetic in ear, nose and throat surgery. Nirvanin, a derivative of orthoform, is a white powder, very light, of a caustic bitter taste, and soluble in water. In its local action it is less powerful than cocain or eucain, slower of action, and much less toxic. In addition to this it has a slight antiseptic action. For injection solutions of from 1–5 to 1 per cent. are sufficient, whereas for application to mucous surfaces 15 to 20 per cent. solutions are required to produce effective anesthesia. Applied to the throat it does not produce the disagreeable constricting sensation produced by cocain, but the anesthetic effect is less pronounced and the pharyngeal reflex is not abolished. In the nose it causes but very slight contraction of the erectile tissue and sensation is not entirely abolished.

As a result of his observations the author arrives at the following conclusions: Nirvanin can not replace cocain altogether as it is less effective, but can be employed as a good substitute where from special causes cocain is contra-indicated. It is readily prepared in solution for application and is the least toxic of the local anesthetics now in use.—*Archives International es de Laryngologie, d'Otologie et de Rhinologie*, March-April, 1900.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

Sympathetic Ophthalmia Treated by Sodium Salicylate.—H. Gifford (Omaha) reports three cases treated with this drug, which he recommends as the most important remedy for

this disease. It should be given in very large doses. Thus, to a boy weighing 130 pounds he gave 180 grains in the twenty-four hours, giving it in 15-grain doses in a teaspoonful of brandy. In all of these cases the control of the drug over the inflammatory condition appears to have been very marked.—*American Journal of the Medical Sciences* from *Annals of Ophthalmology*, January, 1900.

Tobacco Amblyopia.—E. Lopez (Havana), in reporting a case of this disease, remarks that it is rare in Cuba, amblyopia due to alcoholic indulgences being a more common form. This he ascribes largely to the quality of the tobacco generally used on the island. Lopez's patient, a man aged forty years, improved rapidly upon suspending the use of tobacco and taking potassium iodide in increasing doses.—*American Journal of the Medical Sciences* from *Anales de Oftalmologia*, February, 1900.

Iridectomy with Removal of Lens Capsules and Lens Debris in a Case of Blindness of More Than Thirteen Years, with Recovery of Vision.—At the meeting of the Section on Ophthalmology, College of Physicians of Philadelphia, Dr. Charles A. Oliver gave a detailed account of the above case. The patient had both eyes rendered useless by a mining explosion. The left eye had become blind and shrunken. A large field of good light perception in the quiet right eye gave promise of a betterment of his condition, and the procedure noted above was attempted, the result being a permanent vision of 5-25.

Medical News Items.

The American Medical Association held its fifty-first annual meeting at Atlantic City, June 5–8, 1900, Dr. W. W. Keen, of Philadelphia, presiding. Among matters of general interest in the general sessions were noted the president's annual address on "the Endowment of Medical Colleges." Dr. Keen began the address with a commentary on the membership of the Association, now 9000. He touched upon the prosperity of the

Journal of the Association, with a circulation of about 15,000 copies. Reference was made to the appointment of Dr. James C. Wilson as the chairman of the Rush Monument Committee. In some detail the efforts of the association against the Gallinger bill were related by the president. After reviewing other pertinent matters, the doctor finished with a strong argument for the endowment of medical schools. A comparison was drawn, showing the paucity of endowments to medical schools as opposed to theologic, to museums, libraries, hospitals, etc. The dependence upon fees from students discounts the advantages afforded. The expansion into laboratory experimentation, the facilities for research in all branches of medicine, are all handicapped by lack of funds. "In pleading for these endowments of medical schools," says Dr. Keen, "it is but a plea for a return to the profession of a tithe of what they have given. Two years ago I carefully investigated the value of the services rendered to the poor in the city of Philadelphia by the medical staff of the Jefferson Medical College Hospital alone, and I found that 129 medical men were then attached to the hospital, and their services, calculated on a very moderate basis of ordinary fees, I valued at over $500,000 to a profession which gives so freely of that which is most difficult to give, its own life-blood. Surely the public, for its own protection, may give reasonable endowments to its medical schools. It will be returned to the community tenfold, in better educated, better trained and more successful doctors."

The oration on Surgery was delivered by Dr. W. L. Rodman, of Philadelphia, and on State Medicine by Dr. Victor C. Vaughan, of Michigan.

The receipts for 1899 were $39,000. On December 13, the cash on hand was $13,556.56, the total assets amounting to $27,396.86. The report of the Board of Trustees showed a cash balance on June 1 of $4131.36 in addition to moneys invested.

The Association Medal was awarded to Dr. A. L. Benedict, of Buffalo, N. Y., for a paper on "Quantitative Tests for Proteolysis."

The Nicholas Senn Gold Medal was won by Dr. F. Frederick Connell, of Chicago, for a paper on "Exstrophy of the Bladder."

Upon the report of the nominating committee the following officers and committees were elected: President, Dr. Charles A. L. Reed, of Ohio; first vice president, Dr. A. W. Calhoun, of Georgia; second vice president, Colonel Woodhull, of Maryland, U. S. Navy; third vice president, Dr. Phillip Marvel, of New Jersey; fourth vice president, Dr. W. E. Quinn, of Illinois; treasurer, Dr. Henry P. Newman, of Illinois; secretary, Dr. Geo. A. Summers, of Illinois; assistant secretary, Dr. Wm. Davis, of St. Paul; librarian, Dr. Geo. Webster, of Illinois.

Board of Trustees.—Dr. Miles F. Porter, of Indiana; Dr. E. Fletcher Ingalls, of Illinois; Dr. W. L. Rodman, of Pennsylvania; Dr. James M. Matthews, of Kentucky.

Judicial Council.—Dr. James R. Guthrie, of Iowa; Dr. G. B. Gillespie, of Tennessee; Dr. R. C. Moore, of Nebraska; Dr. Ida J. Heiberger, of District of Columbia; Dr. Jno. B. Roberts, of Pennsylvania; Dr. Chas. L. Rodman, of Connecticut; Dr. L. L. Jepson, of West Virginia.

The next place of meeting will be St. Paul, Minnesota, with Dr. John F. Fulton, of that city, as chairman of Committee of Arrangements.

The American Academy of Medicine met in Atlantic City on the days following the American Medical Association. The following officers were elected for the coming year: President—Dr. S. D. Risley, Philadelphia. Vice Presidents—Dr. C. M. McCulver, Albany, N. Y.; Dr. C. G. Graff, Puerto Rico. Secretary and Treasurer—Dr. Chas. McIntyre, Easton, Pa. The selection of the place of next meeting was left to the Council.

The Philadelphia Medical Journal Proposes that the American Medical Association should meet in New Orleans in 1902. It has been some years since New Orleans entertained this body, but we are always ready to show the *esprit de corps* incident to such occasions. Whether it be January, as our friend Dr. Gould, suggests, or May, the Crescent City will find a way to make the welcome hearty.

A Diploma Mill in Chicago known as the Metropolitan Medical College has been put out of business by the Federal courts. The ground of arrest and confinement in jail was the use of the

United States mail for defrauding. The operations of the institution had extended even to Great Britain.

THE MISSISSIPPI MEDICAL RECORD is the new name of our former neighboring exchange, the *Journal of the Mississippi State Medical Association*. The *Record* will hereafter be located at Vicksburg, Miss.

QUARANTINE CHANGES.—The Governor has appointed Dr. J. N. Thomas to succeed Dr. C. P. Wilkinson as Quarantine Officer of Louisiana. Dr. Thomas has been connected with the quarantine station for years and deserves the promotion. His assistants will be Dr. T. Y. Aby at the quarantine station, and Dr. J. Hope Lamb at Port Eads.

THE "WIMBERLY BILL," aimed at emasculating the present Medical Practice Act, met a merited defeat at the hands of the Legislature. It eventuates that the bill was conceived solely to establish an old practitioner who had failed to avail himself of the privilege of registering when he could.

THE PRESIDENT OF THE LOUISIANA STATE MEDICAL SOCIETY, Dr. F. W. Parham, of this city, has issued a circular of appeal, urging interest in next year's meeting of the society. The circular carries the list of chairmen of sections and their collaborators, already published in the JOURNAL.

PERSONAL.—The JOURNAL is pleased to notice the marriage of Dr. H. M. Folkes, editor of the *Mississippi Medical Record*, and Miss Teresa Lopez, of Biloxi. After the ceremony on June 4, the doctor and his bride left for an Eastern trip.

Dr. W. M. Perkins, of this city, and Miss Martha Richmond, were married in June. Dr. Perkins is felicitated by his many friends, the JOURNAL among them.

Dr. R. Von Ezdorf, of the Marine Hospital Service, and sometime in New Orleans, has been placed in charge of the station at Savannah, Ga., in the place of Dr. S. R. Tabb, who died recently.

Dr. R. C. Myles and Dr. Francis J. Quinlan have been elected professors on laryngology and rhinology in the New York Polyclinic. Dr. R. C. Myles is originally from Mississippi and has two well known brothers in New Orleans.

Dr. Samuel G. Grant, recently elected Professor of Rectal and Anal Surgery in the Post Graduate Medical School, has removed from Kansas City to New York City.

The Fair given for the benefit of the Eye, Ear, Nose and Throat Hospital of this city on June 23 and 24, besides affording entertainment to large numbers of people, has netted a handsome amount to this worthy institution and demonstrated the esteem which the community has for it.

The Executive Committee of the XIIIth International Medical Congress has decided that dentists not doctors of medicine, but holding a State diploma, French or foreign, can become members of the Congress in the section of stomatology.

Mortuary: Dr. D. P. Calhoun, of Jonesville, La., died in May at the age of 81 years. The Doctor was well and favorably known, and his death is much regretted in the community in which he practiced up to the time of his death.

Book Reviews and Notices.

All new publications sent to the Journal *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* Journal *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Diseases of the Nose and Throat. By J. Price Brown, M. B., L. R. P E. Illustrated. The F. A. Davis Co., Philadelphia, 1900.

The work is intended as a guide book for the general practitioner and as such is a fair compilation of the current literature relating to diseases

of the nose and throat. It is not, however, in itself adequate to the needs of the active specialist who already has at hand the complete works of the writers of the day and looks to the new publications for improved ideas and recently discovered facts in the pathology and treatment of diseases.

In the compilation of a book it is difficult enough to be brief and at the same time to be explicit and thorough, and the author has not quite succeeded in overcoming this difficulty. Thus, in his treatment of the subject of accessory sinus diseases, he fails to mention the Caldwell-Luc operation for maxillary empyema, and he does not even consider frontal sinus diseases as coming into the domain of the rhinologist, but refers this subject to works on the eye. This is contrary to the usual understanding of the question and is misleading to those who wish to familiarize themselves with the diseases included in this special branch.

There is no excuse for this omission as full space is given ethmoidal disease, which comes as near being in the domain of the oculist as does frontal sinus disease.

Thus the book may be useful for the general pratitioner, but is not complete in its make up and is too lacking in originality to be of value to the specialist. DE ROALDES & KING.

The Year-Book of the Nose, Throat and Ear. By G. P. HEARD, M. D., and ALBERT H. ANDREWS, M. D. Chicago Medical Book Co., Chicago, 1900.

This very creditable work represents a critical analysis of the latest journal articles and publications on the subjects under its title, and is a most valuable reference book for those wishing to consult the latest literature in this specialty. It fills a generally felt want for a book of this kind in English, and as the first volume of a series to be published in the future by these authors, it deserves due credit, and they have taken a good step in the right direction.

The volume contains 274 pages without illustrations, the subjects being arranged in systematic order and carefully indexed both for the subjects and the authors. It contains besides a very convenient list of current medical periodicals in all languages.

The authors deserve encouragement to further work in this line; it is both important and useful. DE ROALDES & KING.

A Pocket Medical Dictionary. By GEORGE M. GOULD, A. M., M. D. Fourth edition. P. Blakiston's Son & Co., Philadelphia, 1900.

With 30,000 words defined and pronunciation marked this little volume meets the demand for a handy dictionary for desk or lecture room.

A Dictionary of Terms Used in Medicine and the Collateral Sciences. By RICHARD D. HOBLYN, M. A. (Oxon). Thirteenth edition, revised by John A. P. Price, B. A., M. D. (Oxon), Lea Bros. & Co., Philadelphia and New York, 1900.

In nearly 850 pages, this arrangement of medical terms is presented with exceeding carefulness in detail. The definitions are clear, the etymologic origin of words is brought out, and the arrangement of type so well observed as to make the work convenient. The publishers have been as careful in the letter press and binding. DYER.

A Handbook for Nurses. By J. K. WATSON, M. D. (Edinburgh). American Edition, Under the Supervision of A. A. STEVENS, A. M., M. D. W. B. Saunders, Philadelphia, 1900.

The scope of this work is made broader than is usually aimed at in a nurse's text-book. Besides presenting the customary information in physiology and skeletal anatomy, the author, in an extensive manner, details the function of the nurse in medical, obstetric, gynecologic and in surgical cases, before, during and after operation. While the extent of detail may be open to criticism, the method of demonstrating the nurse's obligation in a surgical operation is altogether commendable. From the preparation of the patient, the author carries the nurse through the detail of the operation, suggesting at each point wherein the nurse may be needed. A number of commoner operations are related in this wise. The whole book is full of practical teaching, and is characterized by forcefulness in detail. The marginal captions help materially in making the book useful for reference. DYER.

Mentally Deficient Children: Their Treatment and Training. By G. E. SHUTTLEWORTH, B. A., M. D. Second Edition. H. K. Lewis, London. P. Blakiston's Son & Co., Philadelphia, 1900.

First reviewing the history of the study of idiots and congener types of mentally deficient children, the author relates the commoner types of these, illustrating from his case book. A pathologic classification follows, illustrated to show the varying types, First referring to surgical and other procedures for the relief of the conditions at fault, a valuable and interesting chapter is devoted to the educational method of treating such children. Several statistic tables conclude the book. The work throughout is an appeal for the early recognition and constant training of the imbecile child, with the hope of reclaiming the few. DYER.

The International Medical Annual and Practitioners' Index for 1900. E. B. Treat & Co., New York and Chicago.

The eighteenth volume of this well known publication is full of practical suggestions, being a review of all branches of medical science for the year past.

Lea's Series of Pocket Text-Books; Chemistry and Physics. A manual for students and practitioners. By WALTON MARTIN, PH. B., M. D., and WILLIAM H. ROCKWELL, JR.

While in nowise suited for the ordinary medical student because of the synoptic arrangement, the chapters on Chemistry in this book will prove a useful compend for quick reference, as the elements and their properties and relations are clearly, if succinctly, given.

Very much more care has been spent upon the detail of the chapters on Physics; here, definitions are clear and expanded, while a sufficient number of illustrations are given to elucidate the text. DYER.

Progressive Medicine. A Quarterly Digest, etc. Edited by HOBART A. HARE, M. D., Assisted by CHARLES H. HOLDER, M. D. Vol. 1, March, 1900. Lea Bros. & Co., Philadelphia and New York, 1900.

Drs. Alexander Blackader, J. Chalmers DaCosta, Ludvig Hektoen, Frederick A. Packard, Robt. L. Randolph and H. Logan Turner, are among the contributors to this volume of Progressive Medicine, including articles on Surgery of the Head, Neck and Chest; Infectious Diseases; Diseases of Children; Pathology, Laryngology; Rhinology and Otology. Among the very few illustrations, there is one excellent colored plate, showing Koplik's spots in measles.

Hektoen's contribution on Pathology is especially worthy of attention.

PUBLICATIONS RECEIVED.

A Text-book of Practical Therapeutics, by Hobart Amory Hare, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

A Practical Treatise on Sexual Disorders of the Male and Female, by Robert W. Taylor, M. D.—Lea Bros. & Co., New York and Philadelphia, 1900.

A Text-book of the Medical Treatment of Diseases and Symptoms, by Nestor Tirard, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

A Manual of Obstetrics, by A. F. King, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

Maritime Quarantine—Board of Health of the State of New Jersey, 1900.

Transactions of the Associated Physicians of Long Island, June, 1898, to January, 1900.

Memorial of the Prison Reform Association of Louisiana, 1900.

Normal Histology, by Edward K. Dunham, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

Progressive Medicine, edited by Hobart Armory Hare, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

Mosquitos and Malaria—Published by McKesson & Robbins, New York.

Contributions from the William Pepper Laboratory of Clinical Medicine—University of Pennsylvania, 1900.

Reprints.[1]

The Therapy of Feminine Hernia in the Adult—Hemorrhage and Circulatory Disturbances in Complicated Fracture—The Management of Large Congenital Exomphalos, Infantile—On Radical or Tentative Treatment of Piles, by Thomas H. Manley, M. D.

Cholangiostomie—Two Cases Recovering—Eleven Cases of Castration and Their Histories—Ovarian Pregnancy; Report of a Case at Full Term—Case History and Photograph, by B. Merrill Ricketts, M. D.

Blastomycetic Dermatitis (Pseudo-Lupus Vulgaris, Saccharomycosis Hominis, or Pseudo-Epithelioma with Blastomycetes)—Value of Formaldehyde in the Disinfection of Buildings, Rooms and Cars—Tubular Knee Disease, by John E. Owens, M. D.

Gastrotomy for Traumatic Stricture of the Esophagus—Report of Case—Treatment of Cancer of the Cervix of the Uterus Complicated by Pregnancy, by George Ben Johnston, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR MAY, 1900.

CAUSE.	White.....	Colored...	Total .....
Fever, Malarial (unclassified)	1	3	4
" " Intermittent			
" " Remittent	1	2	3
" " Congestive	1	2	3
" " Typho			
" Yellow			
" Typhoid or Enteric	7	4	11
" Puerperal			
Influenza	2		2
Measles			
Diphtheria			
Whooping Cough		1	1
Apoplexy	5	5	10
Congestion of Brain	2	3	5
Meningitis	8	2	10
Pneumonia	15	24	39
Bronchitis	6	11	17
Cancer	7	2	9
Consumption	32	42	74
Bright's Disease (Nephritis)	22	12	34
Uremia		1	1
Diarrhea (Enteritis)	15	13	48
Gastro-Enteritis	13	3	16
Dysentery	5	3	8
Hepatitis	2		2
Hepatic Cirrhosis	5	1	6
Peritonitis	1		1
Debility, General	1	4	5
" Senile	15	5	20
" Infantile	3	8	11
Heart, Diseases of	25	14	39
Tetanus, Idiopathic			
" Traumatic	4	3	7
Trismus Nascentium	4	3	7
Injuries	12	5	17
Suicide	3		3
All Other Causes	139	115	250
TOTAL	376	292	668

Still-born Children—White, 21; colored, 19; total, 40.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 21.25; colored, 38.88; total, 26.72.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure 29.98
Mean temperature ..... 76.
Total precipitation, inches 2.9
Prevailing direction of wind, southeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. AUGUST, 1900. No. 2.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

CONCOMITANT MEASLES, CHICKEN-POX AND SMALL-POX.

BY OTTO LERCH, A. M., M. D. PH. D., CHIEF OF CLINIC TO THE CHAIR OF THERAPEUTICS AND CLINICAL MEDICINE, MEDICAL DEPARTMENT, TULANE UNIVERSITY, ETC., NEW ORLEANS.

CHICKEN-POX AND MEASLES.—Searching through the literature I have not been able to find the record of a case showing the concurrence of these two exanthematous diseases, though I have seen it stated that both diseases may occur together. The case observed by me seems to be of special interest as it shortly preceded the prevalence of variola and varioloid in New Orleans, and occurred when measles was epidemic in this city. The residence of my little patient is located within a few blocks of a large institution in which at the time almost every child had passed or was passing through this disease.

On December 9, 1899, my patient, a delicate but healthy boy twelve years of age, was complaining of headache and general malaise; this, with a general droopy condition, continued so to the 16th, when he showed an entire loss of appetite; in fact he refused to eat. During the night of the 16th, he had chilly sensations, but up to the 17th there was no rise of temperature. On the evening of that day the temperature rose from normal to 104 deg. F., not preceded by a chill; pulse 120. On the morn-

ing of the 18th, the eruption was first observed. The exanthem was quite characteristic. A number of vesicles, about 30 to 40, varying in size from a pinhead to that of a pea, had appeared on the trunk, mostly covering the back, interspersed with small slightly elevated rose-colored spots. On the 19th, the exanthem had covered the whole body, the face included, and a number of vesicles could be observed upon the soft and hard palate and the tongue, causing pain on swallowing even the liquid food that was administered. On the 20th, small papules, vesicles and quite a number of pustules could be observed together in close proximity; within four days three successive crops were readily made out. The temperature had been continuous during this time; the evening temperature ranging from 102 to 103 deg. F.; morning temperature 101 and 102 deg. The patient was now free of fever and in good spirits until Sunday, the 23d, when he suddenly was taken with severe headache, nausea and vomiting, the temperature rising to 104 deg., preceded by a distinct chilly sensation. At this time, the conjunctivæ were reddened, watering, and the child would sneeze frequently and complain of a burning sensation in the eyes. The catarrhal symptoms, however, were not severe, though a bronchial catarrh indicated by a dry cough and husky voice was also present.

On Monday morning the temperature was 100 deg. and remained so till Tuesday night, when the characteristic eruption of measles made its appearance upon the face, gradually spreading downward on the succeeding days. With the eruption the temperature rose to 101 deg., dropping in a few days to below the normal.

The boy made an uneventful and complete recovery. The urine did not contain at any time during the disease albumin, though it always was loaded with phosphates. The concurrence of these two eruptive diseases in a patient when, as before mentioned, measles had assumed an epidemic character, and variola and varioloid were soon to become rather frequent in the city, and when chicken-pox was occasionally heard from, lends a special interest to the case. Both diseases ran a clearly distinct course, but little deviating from the ordinary. I have been unable to trace the infection to a definite source. The city, however, was infested, and the little fellow went to school till the first symptoms appeared.

Prodromal symptoms, such as headache, lassitude, fever and chills are unusual in chicken-pox; in our case they are present from the 9th to the 17th, and the temperature, which as a rule, does not rise more than two degrees above the normal and often is found entirely absent during the whole attack, rose to 104 deg. F. preceding the morning the eruption was first observed. Another symptom, the vesicles, their quick development, the successive crops of lesions, showing the different stages of development in close proximity, make the case a typical one of varicella.

Looking over the succeeding attack of measles we also find it but little altered, if at all; chilliness preceding a rise of temperature to 104 deg., catarrhal symptoms present, and photophobia marked, and the typical eruption with some rise of temperature.

The record of this case shows that chicken-pox and measles may occur together, and that in this case neither of the two diseases is much influenced by the other. The time of incubation is practically for both the same—that is, from one to two weeks.

Various micro-organisms have been described, yet none has so far been proved to be the specific cause for either of these exanthemata. No one doubts, however, that for both diseases such a cause does exist, and the foregoing case demonstrates well that these germs, whatever they may be, can grow like plants on the same soil, and at the same time, without interfering with each other; nor are the toxins they excrete toxic to each other; neither do they alter the symptoms each produces in the human organism.

MEASLES AND VARIOLOID.—This is a complication, though no doubt sometimes mistaken, which does not occur very frequently, judging from a lack of literature. I have not been able to find a case recorded; and like the foregoing reported case of chicken-pox and measles, it seems to be of special interest, occurring at a time when both these exanthematous diseases were coexisting side by side, and when the former, as mentioned, had preceded the latter as an epidemic and was gradually subsiding, due, perhaps, to the material becoming more scanty.

The patient, a young man of 28 years, with a good hereditary history and a history of measles in childhood, and of revaccination when ten years of age, was in perfect health till

February 20, 1900, when he commenced to complain of headache, general malaise, soreness in the muscles and catarrhal symptoms, cough, sneezing and conjunctivitis. The evening temperature was 101 deg. Taking these symptoms to be due to a "cold," he continued his business of a clerical nature until the 23d. During this time the temperature gradually rose to 103 deg. F., and in the evening of that date he felt chilly. In the morning the temperature was 102 deg., and the characteristic eruption of measles had made its appearance. Photophobia was well marked and the room had to be darkened.

The eruption gradually spreading from forehead over face and trunk, was punctate and papular in character. The temperature rose gradually, and steadily commenced to decline, till the thermometer registered 100 deg. On the evening of the 27th the patient, who, up to this time, was in excellent spirits and suffering no pain, experienced excruciating headache, severe pains in back and limbs, nausea and vomiting. The temperature rose again to 104 deg., and was initiated by a *severe chill, followed by profuse perspiration*, soaking the bedclothes. On the morning of the 28th the characteristic eruption of small-pox was covering forehead and scalp, giving the flabbly feel beneath the skin to the palpating finger, proceeding to trunk and extremities, palms of hand and soles of feet. The finely papular eruption of measles, though faded, was still present, so that at this stage of the disease the two papular eruptions, distinct in character, could be studied. The evening temperature was normal and remained so. The eruption never matured. On the fifth day after the initiating chill the patient was out of bed and had practically recovered.

In this case the source of infection could readily be made out. On the 15th my patient had seen a sick friend of his, who later on proved to be suffering from small-pox. As to the measles, as he expressed it, "every child in the neighborhood was down with it." We have to consider that it is sometimes exceedingly difficult to differentiate between the "roseola variolosa" preceding, not infrequently, the *eruption of small-pox*. This rash seems to have been especially frequent in the widespread and malignant epidemic of 1871 and 1872.

Welch says: "Some authors describe it as presenting an erythematous or scarlatiniferous appearance, but according to

my observations it more nearly resembles the rash of measles. So close, indeed, is the resemblance that the first time I met with it I fell into the error of supposing the case to be one in which measles and small-pox coexisted." The same author further remarks that it occurs as often in varioloid as in variola, and mentions two cases in which this eruption was the only one that occurred.

In the case recorded we see that the patient was stricken when measles and small-pox were prevalent in the city, and that he was exposed to both infections. We have traced his infection of small-pox to definite source, and as to measles he stated that at the same time he was repeatedly exposed to the disease. We see, further, that each disease is preceded by its characteristic prodromes; has a distinct onset, and runs a definite course, each exhibiting the symptoms we are accustomed to consider diagnostic for the disease:

The gradual rise of temperature, lassitude and general malaise, catarrhal symptoms, photophobia, chill and eruption in the usual time with elevation of temperature—characteristic measles; the excruciating headache, severe pain in back and extremities, gastric symptoms, sudden rise of temperature, severe chill followed by profuse sweating, appearance of eruption and with it the drop of temperature, furnish a distinct clinic picture of varioloid. It seems to me that no doubt is left that in this case measles and varioloid coexisted, especially when we consider that at one time the patient presented the characteristic cutaneous lesions of both diseases. All that has been said in concluding the former case may be repeated: Whatever the specific germs are that cause these exanthemata, they can grow like plants on the same soil and at the same time without interfering with each other, nor are these excreta toxic to each other, and neither do they alter the symptoms they produce in the human organism.

Judging from the coexistence of both diseases in the city, it seems that *conditions favoring growth and spread of one disease are equally favorable for the other.*

I will briefly relate a case that came under my observation at this time, which, as far as it goes, seems to support this conclusion.

A young man 20 years of age, member of a wealthy family

living in a most desirable locality of the city, developed a case of varioloid. The patient was immediately isolated and every member of the household, seven in number, was vaccinated and revaccinated, with the exception of one of the servants; every one developed a good case of cow-pox. About two weeks later, the youngest one of the family, a healthy boy 8 years of age, commenced to show the prodromes of measles, droopy condition, photophobia and catarrh, followed in the usual time by all other symptoms of the disease, making a good recovery. About 3 weeks later the same little patient developed a characteristic case of varicella.

Within two months I located in this family small-pox, chicken-pox and measles. *These three exanthemata may coexist as epidemics in the same city; they may coexist in the same house; they may coexist in the same patient and may run their usual courses.* Much has been said of a rash that precedes small-pox, sometimes described as presenting an erythematous or scarlatiniferous appearance, and again that it resembles measles.

Welch, as stated before, mentions a case which he took for some time as one of small-pox complicated with measles, and he records two cases of small-pox in which the morbilliform eruption was the only one that occurred.

Sydenham speaks of an unusually bad kind of measles as prevailing in London in 1670 and 1674, at a time when variola also was remarkably malignant and fatal.*

Fagge has said, "when one finds the older writers laying great stress upon 'black measles' one is almost inclined to suspect them of having mistaken cases of hemorrhagic small-pox for this disease."

In the malignant and widespread epidemic of 1871 and 1872 the rash of measles was especially noticed. In the writings of modern authors we meet again and again with the statement that cases of hemorrhagic small-pox are frequently mistaken for measles.

During our recent malignant and fatal outbreak in New Orleans, Dr. Kohnke, the president of the City Board of Health, testified that the percentage of death rate in the small-pox hospital (pesthouse) was 31.10 and at residences throughout the city

*Williams on Measles.

34.93. A mortality appalling when we consider that due to house inspection and to the popular dread of the disease this percentage is taken from figures, including the mildest case of varioloid. This preceding eruption of measles and "black measles," confluent hemorrhagic small-pox, again has called forth special notice.

Again prominent physicians have, during the first days of the disease especially, when measles was epidemic and small-pox not yet prevalent, taken the eruption as a symptom of the former disease. In fact this so frequently occurred that laymen with a suppressed smile would designate a case of small-pox one of measles.

The writer had an opportunity to observe a case of the hemorrhagic type of small-pox (black measles!) in a woman thirty years of age. The onset was sudden, high fever, chill and fainting, for three days thermometer registering from 103 to 105 deg., conjunctivitis, protophobia and cough present, face puffy. Third day characteristic eruption of measles, high temperature, continuous to seventh day. Eighth day, subcutaneous hemorrhages and fall of temperature below normal. Temperature remained slightly subnormal, to the fatal ending on the eleventh day. In this case no other eruption except that of measles was at any time observed.

Patient had been exposed to both diseases.

I do not think that we have a right to doubt Sydenham and the older writers, whose senses it should seem were far better cultivated than ours, as they had to depend entirely on them for a correct diagnosis, with a far better field for investigation, when they give us their observations in regard to "black measles."

All our modern means of research, so efficient in almost every other disease, are so far useless in settling the question of identity of these exanthemata.

Further, the most prominent clinicians of the present day openly avow that they have taken the eruption as a symptom of measles till characteristic symptoms of small-pox made them alter their diagnosis.

COMMENT.—It seems that small-pox has a tendency to spread and become malignant when an epidemic of measles prevails.

The rash of measles preceding small-pox is noticed especially at these times. Black measles and the hemorrhagic form of small-pox are reported. We have seen that it seems probable, at least, that the conditions favoring the growth of one of these diseases favor also the growth and spread of the other.

We have further seen that they do occur in the same individual at the same time and run their usual course, and that the rash of measles preceding small-pox is especially observed during times when both diseases are epidemic, and as small-pox spreads and becomes malignant, it does not seem farfetched to suggest that this rash really is a symptom of measles *complicating small-pox and causing its malignancy and spread.*

Though this proposition, of course, can not be proven until bacteriologists have settled the question, it seems wise, meantime, to act upon the suggestion and to isolate and treat measles as we treat and isolate small-pox, or any of the more dreaded acute, infectious diseases, with the greatest care, even when cases of small-pox are known to exist in the community.

People are not generally aware of the fact that measles is a dangerous disease in itself; one of the most dangerous with which a child under five years can be attacked.

REPORT OF A CASE OF DERMATITIS EXFOLIATIVA RECURRENS.*

By A. R. ROBERTSON, M. D., Pass Christian, Miss.

The diagnosis and treatment of rare skin diseases is more or or less puzzling to the general practitioner, especially in the country, where his field for observation is necessarily limited, and his library facilities small.

The country doctor can not steal around the corner to the office of his dermatologic confrère, as our city members are wont to do, for a friendly pointer, or turn the case over to a specialist, as is his duty, but must shoulder the entire responsibility and do the best he can until Nature has come to his assistance, or the case passes into the hands of another who may be more fortunate in his diagnosis.

---

*Read before the Louisiana State Medical Society Meeting, New Orleans, April 19, 20, 21, 1900.

The case which I am about to report should therefore prove interesting to a majority of the members of this society, and especially so to those living in the country.

My patient was a white man, aged 37 years, married, and living on the beach five miles east of Pass Christian. Occupation, truck farmer. Previous health and family history good.

His sanitary surroundings were excellent, the premises being drained by a fresh water creek. His drinking water is obtained from a drove well, thirty-five feet in depth.

I was called to see him on September 24, 1899, and found him in bed, with a temperature of 105 deg; pulse, 130.

He informed me that he had been taken suddenly with a chill a few hours before.

He did not complain of any other symptoms, and assured me that he felt well enough to sit up.

The bowels were constipated and the tongue very much coated. His kidneys were acting freely.

There was no enlargement of the liver or spleen.

The whole surface of his body below the neck, including the extremities, was of a bright red or scarlatiform color, the region of the navel being especially inflamed. The inflammation resembled somewhat the severe sunburn so often seen in our city visitors after a cruise over the lake on a hot July day.

I inquired whether he had been exposed unusually to the sun, and he informed me that he had been in the water drawing his seine on the previous day, but that he frequently did so without any bad results.

After questioning him closely I was at a loss to account for the severe dermatitis, except that it might possibly be attributed to the exposure to the sun and salt water while hauling his seine.

Not being entirely convinced that the patient was suffering from malarial fever, although his drinking water was not boiled, and thinking that the febrile condition might be due to the exposure to the sun's rays the day before, I administered 2½ grains of phenacetin, ordered cool sponging to control any further rise of temperature, and prescribed 6 grains of calomel and soda to be divided in four powders, one to be given every hour, and decided to await results.

On my return the following day I found my patient sitting up with a normal pulse and temperature, his skin being even more inflamed than on the previous day.

Several days after, while passing the house, he called my attention to the palms of his hands, which were dry and hard and without sensation. Having seen similar conditions in the hands of fishermen and oyster openers, I did not attribute any importance to it.

I next saw my patient on November 6, when his temperature was 104 deg., pulse 120, his symptoms being about the same as they were when I saw him first, only the dermatitis was confined to his hands, arms and body from his waist down to two inches above his knees, and his feet and legs as high up as his shoe tops.

He informed me that he had shed his skin from nearly his entire body after his first attack, and that he had had a similar attack on October 16, which was also followed by desquamation, the cuticle coming from his back and chest in large paper-like flakes several inches in size, and that from his hands and feet in complete glove-like casts. Calomel and soda was again administered, and he was put upon ten-drop doses of arsenauro three times a day, which was kept up for several weeks without any apparent benefit, the disease continuing to recur, though gradually, in a milder form. Quinin was then ordered and seemed to be of some benefit, the attack growing rapidly less severe.

The patient had eight distinct attacks of the disease, which grew progressively milder until recovery was established. The first on Sunday, September 24, 1899, with a chill and high temperature. Location of rash—Entire surface of body below the neck and including the extremities. Desquamation commenced on fifth day. The second attack on Monday, October 16, with chill and high fever. Location of rash—Arms, from about three inches above elbows down to and including the hands, and from the groins down to and including the feet. Desquamation commenced on eighth day. Third attack Monday, November 6, with chill and high fever. Location of rash—Hands and arms, as in second attack; waist, groins, inner surface of thighs to two inches above knees, feet and legs as high up as shoe tops. Desquamation commenced on fifth day. Fourth attack on Monday, November 27, with chill and fever. Location of rash—Same as in third attack. Desquamation commenced on seventh day. Fifth attack on Monday, December 18; fever. Location of rash—On hands and feet only. Desquamation commenced on

eighth day. Sixth attack on Monday, January 1; fever. Location of rash—Hands, as usual; feet mildly. Desquamation commenced on fifth day. Seventh attack on Sunday, January 21. Location of rash—On hands, mildly. Desquamation commenced on seventh day. Eighth attack on Thursday, February 6. Location of rash—On palms of hands only. Desquamation commenced on eighth day.

It will be readily seen that the periodicity of these attacks was not uniform, the second, third, fourth, fifth and seventh being three weeks, the sixth and eighth two weeks. Desquamation would be complete in about ten to fourteen days, leaving a smooth, shining surface, very sensitive to variations of temperature. The toe nails were shed during his third attack. The finger nails were not shed, but were marked by eight transverse parallel grooves about $\frac{1}{16}$ of an inch apart. Alopecia occurred in a moderate degree during the course of the disease.

The patient is now in excellent health and has gained in weight. Statistics at my command do not give a clear idea of the frequency of the disease.

Blanc[1] reports one case of exfoliative dermatitis in 373 cases of various skin diseases occurring in his wards in the Charity Hospital during the year ending December 1, 1887.

Charles E. Lockwood,[2] of New York, in a general practice of twenty-five years, saw only one case.

Hardaway describes three forms of exfoliative dermatitis—acute, chronic (also called pityriasis ruba) and dermatitis exfoliativa infantum. The acute form, often recurrent, may be mild and limited to certain portions of the body, preferably the hands and feet, or extend over the entire cutaneous surface with little constitutional disturbance. This is the scarlatiniform type of some authors. It may be also very severe and rapidly fatal.

Diehl[3] reports a case of milder variety "in which, without preceding or accompanying disturbance, the eruption began on the wrist and ankle and soon enveloped the whole surface. In eight days it was at its height and then was followed by copious desquamation and improvement."

Of the severe variety, Morrow's[3] case is a good example, his

1 NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, February, 1888.
2 *Medical News*, September 16, 1896.
3 *Progressive Medicine*, September, 1899.

patient presenting a generalized eruption, simulating erysipelas in appearance. There was free exfoliation and a temperature elevation ranging between 102 and 105 degrees. There was also considerable inflammation of the parotid gland. Later abcesses developed in the perineum and other regions of the body. The case terminated fatally within six weeks after its first appearance.

Quinin has been known to cause the disease.

It may follow typhoid fever or streptococcus infection.

Dr. A. Lantz,[4] of Moscow, reports a case following a dose of opium. Patezon's[5] case was in a rheumatic and followed severe fatigue and exposure to cold. The diagnosis of acute exfoliative dermatitis is often difficult and may be confounded with scarlet fever, erysipelas, the medical rashes of the chronic form.

It may resemble scarlet fever so closely during the first few days that a diagnosis is impossible, but the condition of the throat and tongue does not resemble scarlatina.

Desquamation is often even more complete than in scarlatina. The acute form has a sudden onset with chill and elevation of temperature, and a rash which rapidly spreads over the surface of the body. They may be systematic disturbance which is particularly well marked in the relapsing cases. The inflammation may be local or more or less general, the skin is at first scarlatiniform, violaceous or of a dusky hue which lasts four or five days, ending in desquamation.

The cuticle is shed in "large or small thin papery scales which, on the scalp, are furfuraceous, on the body and upper portion of the extremities large and more or less imbricated, while on the hands and feet it may be shed in thick glove-like pieces," leaving a smooth, shining, sensitive surface.

The hair and nails may also be shed as well as the mucous membranes. The case may be complicated by an ephemeral eruption of vesicles, blebs or pustules, and the general state of the patient may excite much apprehension from emaciation or serious complications.

The affection may last from a few weeks to several months, the relapses generally growing milder and milder until the patient is entirely well.

---

4 *American Medical and Surgical Bulletin*, July, 1893.
5 *Medical News*, May, 1894.

Dr. Ohmann Dumesnil,[6] of St. Louis, prefers the term erythema to that of dermatitis. Blanc also used the term erythema.

The treatment of dermatitis exfoliativa is very unsatisfactory. At the onset a brisk cathartic should be administered, followed by warm baths and pilocarpin to excite the sweat secretion. To allay the itching some soothing ointment or liniment should be used.

Equal parts of lime water and olive oil containing one per cent. of carbolic acid should prove beneficial.

The calamin and zinc ointment has been recommended.

William White, in his Dictionary of Treatment, claims to have seen complete recovery under appropriate treatment in three cases. He does not believe internal remedies are of much benefit, unless it be from small doses of arsenic combined with a diaphoretic and diuretic. He protects the entire cutaneous covering of the body from the irritation produced by contact with the air and variations of temperature, using inunctions of of some animal or vegetable fat to which may be added about ten per cent. of simple camphor liniment.

The patient should first take a prolonged bath in warm water, after which the above ointment is well rubbed in and the parts covered with lint which is also well coated, and comfortably bandaged.

He recommends a weak alkaline bath containing starch or a little carbolic acid to allay itching.

Lockwood's case was cured by immersing the hands (the only parts involved) in water, as hot as could be borne, two or three times a day, and the internal administration of Fowler's Solution.

Arsenic is believed by some to do harm, and thyroid extract and the dessicated powder has been disappointing in its results. Quinin seems to be of some benefit, especially in the recurring cases.

[At the request of the author, I am glad to add a word to his paper. His report is interesting and valuable as an addition to literature of erythema recurrens exfoliativum, as I prefer to call it. These cases are unusual enough to excite remark and occasion their report. I must concur fully in the diagnosis made.

6 *Medical News*..

I believe that arsenic is of little or no service in these cases. Those which have come under my care have done best under mild antipyretics (acetate of ammonium and sweet spirits of nitre) during the rise of temperature, and with strychnin and alkaline diuretics, citrate of potash usually, until the desquamation was complete, the strychnin being kept up for months afterward. The local treatment (in four cases I now recall) consisted in two daily baths in full tub of hot water with a pound of laundry starch and an ounce of carbonate of soda. The baths were followed with lanolin and rose water ointment, to which a small quantity of tar or diachylon was added *pro re nata*. —Isadore Dyer.]

TYPHOID FEVER IN CHILDHOOD WITH A REPORT OF THREE CASES.*

By E. D. Fenner, M. D., First Assistant Surgeon, Charity Hospital, Lecturer and Clinical Instructor Diseases of Children, Medical Department Tulane University, New Orleans.

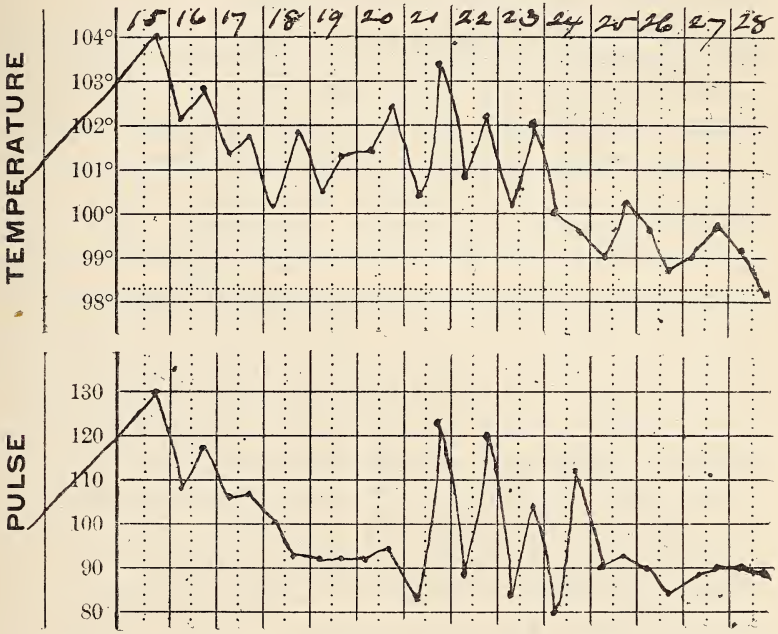
Case 1.—Salvador C., Italian, aged 10 years, admitted to hospital November 16, 1899, suffering from railroad injuries of both lower extremities, for which simultaneous amputation of the right leg at upper third and left leg at lower third was performed. The boy recovered rapidly from the shock of the operation and did well except that some sloughing occurred in the amputation flaps owing to the contusion of the tissues through which section had to be made. Two months after admission, on January 18, 1900, the stumps being practically well, he developed temperature of 104 deg. F., with pulse 130. The existence of measles in the ward at first led to the expectation that fever was that of the onset of this disease.

In a few days the spleen was distinctly palpable, the abdomen distended, gurgles could be heard in the right iliac fossa, the boy's expression was dull and apathetic, and the tongue was coated and pointed. Repeated blood examinations gave the following results:

January 17, free from plasmodium malariæ; January 18, Widal's reaction positive; January 19, Widal's reaction positive; January 22, Widal's reaction positive (1-100); January 30, Widal's reaction positive (1-150).

* Read at the meeting of the Louisiana State Medical Society, New Orleans, April 19, 20, 21, 1900.

The accompanying records of pulse and temperature during the febrile stage indicate the general range of the fever, although these morning and evening records are on some days falsified by the effects of hydrotherapy, which was employed systematically whenever the temperature was high.



The case ran a mild and uncomplicated course, the bowels being rather constipated, and the rose spots not being recorded by the attendants.

CASE 2.—White male, aged 10 years, born in Italy, five years in United States, was admitted on December 15, 1899, suffering from a severe contusion of the knee and a fracture of the great toe. The accident occurred on December 14, the boy being run down by a wagon. On the afternoon of December 15 his temperature was 102-4 deg., and he complained of some pain in the knee and foot, both of which presented considerable swelling. The fever was naturally attributed to the injury, and a splint and bandage were applied to the limb and a calomel purge was ordered at once. Phenacetin was given for the fever and liquid diet ordered. The next morning temperature was 99 deg., the bowels had moved, child had rested well, and his ex-

pression was good. A careful examination of the knee showed the injury not to be serious, there being no effusion into the joint, and little restriction to movement. December 16, evening, temperature 100 deg.; Dec. 17, A. M., temperature 98.2 deg.; P. M. 100 deg.; Dec. 18, 7 A. M., temperature 102 deg.; pulse 124, resp. 24. The expression of the face was a little dull, the spleen could be easily palpated, liver could be felt below costal arch, lungs, heart and other viscera revealed nothing abnormal. Dec. 18, P. M., temp. 104½ deg., and during the night ranged between 101 deg. and 105 deg. In spite of a negative report on the presence of plasmodium malariæ in the blood, quinin in three grain doses was ordered every three hours. December 19, case has a different appearance. His facial expression is dull and he is very listless, tongue is a typical typhoid tongue. A positive Widal and negative malarial report was gotten to-day on the blood. In the course of the next few days the blood reports showed Widal's reaction positive twice with dilution of 1-150, and continued absence of plasmodium. The temperature pursued a characteristic course till January 4, 1900, when it practically resumed a normal level, except for a few very slight elevations. During the febrile period the boy was tubbed thirty-three times for temperature of 103 deg., or over, and in the intervals the ice bag was applied to head and abdomen, as indicated. He made an excellent recovery and was discharged entirely well on February 21. It may be stated that he was retained in the ward long after he was really well of his typhoid.

CASE 3.—Edward B., white male, aged 10 years, was admitted on January 5, 1900, with history of having fever continuously for two weeks. On admission his mental condition was fairly bright, tongue coated, with red edges and pointed tip, spleen easily palpated, kidneys and other organs apparently normal; temperature 102 deg.

Between the sixth and ninth the temperature ranged between 103 deg., the highest, and 99 deg., being most of the time in the neighborhood of 100 deg. On the 14th it went up to 102 deg., and with marked remissions, showed daily maximum records of 101 deg. to 103 deg., till January 21, from which date it remained normal.

Apparently we caught this case at the end of the second week

of typhoid and during the first few days in the hospital lysis was asserting itself. After another week a slight relapse or recrudescence occurred, which in 7 days terminated in complete termination of the fever.

Repeated blood examinations gave uniformly Widal's reaction positive even in high dilution (1-150) and plasmodium malariæ negative.

The treatment in all these cases was alike. The temperature was controlled by the full bath, cooled down from 95 deg., administered whenever the thermometer, which was used every three hours, showed a temperature of 103 deg. Strychnin sulphate gr. 1-96 and salol gr. 2 were given for their tonic and antiseptic effects respectively. The diet was rigidly liquid and was given as freely as the patient could be induced to take it.

These cases are fairly typical of the ordinary typhoid of childhood, and in spite of the fact that all of these boys were nearing the age of puberty, they still exhibit very plainly the influence of the age upon the course of the disease.

Typhoid is admitted to be very rare during infancy. This must be attributed in part to a relative insusceptibility; in part it is perhaps due to the fact that the milk of babies is so frequently boiled before it is administered. It is worthy of mention that ulceration of Peyer's patches is not pathognomonic in the case of infants. Entero-colitis expends its force chiefly upon the lymphatic bodies of the large intestine, the solitary follicles, but it is no uncommon thing to see at post-mortem extensive ulceration of the large bowel, with associated thickening and erosion of Peyer's patches.

After the first two years typhoid is progressively more common as we advance towards adolescence. Throughout childhood, however, it is a milder, less fatal disease than in the adult.

The fever is often rather abrupt in onset, a sharp rise of temperature marking the invasion. This is exhibited by two of the three cases here recorded. The febrile period is generally shorter than in the adult, frequently terminating in 10, 12 or 14 days. In one of my cases fever lasted twenty days, in another 14 days. In the third the patient was brought in after two weeks' sickness, and had fever only three days, followed by a period of normal or nearly normal temperature lasting four days, and then leaving a week of temperature presenting such regular and complete intermissions, that only the repeated find-

ing of the Widal reaction and absence of plasmodium in the blood, induced me to consider the case one of typhoid.

The rose spots are said to be frequently present in children, with a tendency to appear earlier, about the fifth day. It is a symptom not uniformly present and was not recorded in any of these cases.

The nervous system is uniformly affected in typhoid. In childhood apathy and indifference, with considerable irritability are the common condition. Delirium is not often seen, perhaps owing to the imperfect mental development of the child. All of the more severe nervous symptoms, such as coma vigil and subsultus tendinum, are relatively infrequent.

The spleen, as was noted in all our cases, enlarges rapidly and can be readily palpated.

It is a notable fact that ulceration of the intestines is not severe in the young. Not infrequently the Peyer's patches are only slightly eroded; sometimes only swollen. As a natural result we would expect hemorrhage and perforation to be uncommon. Diarrhea is not generally troublesome. Indeed, constipation is as frequent as the former.

The appetite is apt to be very poor in children. Nausea is often seen, and it is frequently very difficult to properly nourish these little patients.

In the treatment of these cases we find little use for drugs. An enema or mild saline to relieve constipation, or a little bismuth and chalk mixture for diarrhea, constitute the whole array of necessary medicine in an ordinary case. For the sake of its tonic and stimulant action, we are in the habit of giving strychnin sulphate in small doses, say gr. 1-96 every four hours, and in some of the cases we use a little salol or other intestinal antiseptic for its effect on the stools. Beyond these there is no need of medicine. Our main reliance is upon good nursing, careful feeding and the control of high temperature by bathing. Much depends upon the efforts of an intelligent nurse. Upon her tact and firmness depends the successful administration of a liberal liquid diet. We seldom employ the coal tar preparations to combat the fever. The more familiar one becomes with the use of hydrotherapy in the treatment of fever, the less one fears its possible dangers. In childhood its effects are particularly gratifying. The warm bath is a powerful sedative to the nervous system of the young. The cold bath,

the temperature of the water being gradually reduced from 95 deg., is the most efficient and the safest antipyretic we can employ. In typhoid we tub whenever the temperature exceeds 102.5 deg., and we turn to the bath with confidence not only in typhoid, but in the pyrexia of pneumonia, of measles and other diseases.

Clinical Report.

TWO CASES OF SEVERE BLEPHAROSPASM AND FACIAL CHOREA RELIEVED BY THE USE OF SPECTACLES.

BY DRS. BRUNS AND ROBIN, NEW ORLEANS.

I. Well nourished young girl of about 20 presented the most severe facial chorea we have ever seen, the face being momently convulsed without rest save during sleep. The condition of her general health being excellent offered no explanation of the malady. R. and L. E. V. $= 20\overline{\overline{xx}}$ fairly.

Stevens' phorometer showed no lack of muscle balance.

Atropin was instilled into both eyes. On the following day, May 24:

R. E. V (atropin) $=20\overline{\overline{cc}}+2\overline{\overline{25s}}=20\overline{\overline{xx}}$.

L. E. V (atropin) $=20\overline{\overline{cc}}+2\overline{\overline{25s}}=20\overline{\overline{xx}}$. (?)

Javal's instrument showed no astigmatism. Already the patient had greatly improved.

June 2. The atropin having been discontinued since the last date the facial chorea had returned; atropin was again instilled and the refraction measured on this and the two following days, and glasses of $+2^{s}$D. were prescribed for constant wear. Relief of the eye strain produced immediate and permanent relief, no trace of spasm remaining.

II. Married woman of 44 years of age. Severe facial chorea only slightly less furious than in preceding case. She had suffered more or less from blepharospasm for the past year, but of late it had become more severe and the convulsions had involved the whole face.

R. and L. V.$=20\overline{\overline{LXX}}$—Manifest hypermetropia$=2^{s}$D.

Javal: R. and L. + 0.75D. ax. 90 deg.

Stevens: Orthophoria at all distances.

On the following day, July 6, R. and L. V$(a)+2^{s}$D$=20\overline{\overline{xx}}$.

The spasm had greatly diminished.

July 7. The refractive finding was confirmed and $+ 2^{s}$D.

R. and L. was ordered for constant wear; spasm had disappeared and did not return.

Both patients were of Jewish blood.

These cases are reported from our practice on account of the high intensity of the symptoms and the prompt relief afforded by relieving the eye strain.

Clinical Lectures.

Specially Reported for the JOURNAL from the Philadelphia Clinics.

I.

THE TREATMENT OF ACUTE JAUNDICE.

By Prof. J. C. WILSON, M. D.

The patient is a young man of twenty-three, with previous good health. The present trouble began one week ago, and the signs now presented are those characteristic of an attack of acute jaundice, the result of gastro-duodenal catarrh.

Catarrhal jaundice is quite common at the present time. There seems to be outbreaks at times when the cases are quite numerous. This has been noticed in boarding schools, etc., though the explanation is not clear.

The essential elements of the treatment are time and a mild form of starvation. Many of the patients have no particular desire for food, and a very light diet is not much of a privation. In the course of a few days, when this plan is adopted, the symptoms begin to clear, and as a result there is a wholesome appetite, which may have to be restrained. I like to restrict such patients to milk for two or three days. A half glass of milk filled up with Vichy water, may be taken six or seven times a day.

As to drugs, nearly every one is apt to begin with calomel. As regards its influence upon the liver, it does good indirectly if not directly. It purges the patient and empties the bowel high up, thus getting rid of mucous, etc., which needs sweeping out. I do not know of any good scientific reason for the use of sodium phosphate as an after administration. A pint of hot water morning and evening, as hot as can be drunk, will be found an efficient aid in cleaning up the mucous membrane. In stubborn cases the rectal injection of large quantities of hot water will often do good. A liter twice a day may be thus used.

Hypodermoclysis of normal salt solution has been used, and it is an efficient means of treatment. The patient under consideration has been thus treated with very gratifying results, two

injections having been used. But while I thoroughly believe in this treatment and use it in hospital cases, I have never yet tried in private practice and do not know that I ever shall. The procedure is not altogether painless and is a rather formidable operation to most patients. The principal reason, however, for advising against this is that there may possibly be an error in sterilization of the instrument in private houses, and an abscess resulting from this means of medication would be a very undesirable consequence. Hence for the present, until methods of sterilization are more sure for the general practitioner, the proceeding should be confined to hospital cases.

II.

INTERESTING EXAMPLES OF TRAUMATIC NEUROSES.

By F. X. DERCUM, M. D.

The first case is that of a woman of thirty-two, upon whom a laparotomy was done in December, 1898. Three days after this operation attacks of sneezing began. These were violent at times, lasting for half an hour and interfering with the patient's sleep at night. Some trouble with the right ear was complained of. Attacks of sneezing were provoked by pressure on the right mastoid and also over the supra-orbital notch of the same side. Some days ago this patient was operated upon for the ear affection, the mastoid being opened. Evidence of disease was found, but no acute process was in progress. Since the operation, however, the patient has been somewhat relieved of her trouble—some symptoms. Sneezing can not be induced by pressure on the mastoid now, and much less readily than before by pressure over the supra-orbital notch.

Hysteria is strongly suggested in this case and examination to determine this will now be made. Regions of tenderness are found along the spine, also on the chest anteriorly and in the inguinal region. This tenderness is superficial, so that slight pressure causes the patient to wince, showing that it is confined to the nerves of the skin.

I wish to speak a little more in detail regarding this tendernesss in the inguinal region. It was believed formerly that this indicated tenderness of the ovaries and was felt only over them or in the near vicinity. This is not the fact, however. The tenderness can be demonstrated to be entirely superficial by examining such patients with one finger in the vagina and the hand upon the external surface of the body. By this means

the area of tenderness can be outlined within a sixteenth of an inch. The same fact is true in regard to areas of tenderness about the breasts—they are in no way related to the underlying structures.

Examining further, we find a hemi-anesthesia affecting the right side. This is less marked in the leg than the arm, but in general it may be said that the sensory loss is more marked toward the periphery of the extremities than near the body or on the right side of the body itself. There are practically no motor disturbances connected with the case. There is a contracted visual field of both eyes. From all these symptoms we have here a well marked case of hysteria.

I believe that the ear disease had nothing to do with the sneezing, there being simply a hystero-genic zone in that region which, when pressed upon, caused the attacks. One woman under observation at one time had such a zone, which, when pressed upon, gave rise to a general hysteric convulsion.

I do not know the previous history of the case before the abdominal operation, but this is very probably a case of traumatic hysteria following that event. Trauma of all kinds does provoke hysteria, and surgical trauma may be the exciting cause. Hysteria of this origin is much more apt to occur in persons who are predisposed to the affection, however. It is very likely that the mastoid operation only acted by suggestion in relieving the attacks of sneezing, which could be provoked by pressure on that region.

The second case is that of a man who was in good health until operated upon for fistula in ano. He had had this fistula for three years, but it did not interfere with his work. About five months ago he was operated upon and made a good recovery from the small operation necessary.

Some time after a beating sensation in the chest was noticed. This increased until it now interferes with his sleep. He falls asleep when he goes to bed, but states that when this sensation wakens him, whether he has slept half the night or half an hour, he can not go to sleep again during that night.

The patient now has trouble with his breath, he tires very easily, has ringing in the ears, acid eructations, etc. He has been obliged to give up his work, not being able to concentrate his mind upon this when getting the least tired.

We have a well-marked neurasthenic syndrome given us as

following the operation mentioned, and have evidently a case of traumatic neurasthenia in contradistinction to the case of hysteria first exhibited.

The treatment here should be the rest method as much as possible. The patient should stay in bed late, eat his breakfast in bed, take a sleep after dinner, and have, perhaps, some regular hours of exercise in the open air. A warm sponge bath in the evening will probably do much toward securing sleep. Milk, vegetables, fruits, etc., should be added to the diet, and meat cut down.

Some simple hypnotic will perhaps be necessary here, and which can be most easily withdrawn, should be used. Trional in the dose of ten grains will answer very well, or perhaps better if five or ten grains of sulphonal be added. Chloralamid is the best of all, but is too expensive for hospital use or even a large number of patients in private practice.

Charity Hospital Notes.

(Specially reported for the JOURNAL.)

I.

MODIFIED HALSTED OPERATION FOR CARCINOMA OF THE BREAST.

BY E. DENEGRE MARTIN, M. D.,

PROFESSOR OF MINOR AND CLINICAL SURGERY IN THE NEW ORLEANS POLYCLINIC.

I present a case of carcinoma of the breast, upon which I propose to perform a modified Halsted operation. The patient is a mulatto female, age 37; occupation, house servant. She came into the hospital three days ago. Her general condition is fairly good. She says she first noticed the growth 18 months ago, when her attention was attracted by a small, hard lump. This lump has steadily increased in size up to the present time. There is no pus present. A diagnosis of carcinoma has been made clinically. I have noticed that this affection is especially prevalent among women of this class, and believe it due to the fact that they perform much work of an arduous kind. Only a portion of the mammary gland is involved, and I regard the case especially favorable for operation. A few of the lower axillary glands are involved, which constitute a small mass the

size of a hickory nut at the base of the tumor; the glands at the axillary apex and in the subclavicular fossa are apparently uninvolved, nevertheless they may be. I begin with the usual Halsted incision, removing the mammary gland and all diseased glandular structure *en masse*, together with the pectoralis major muscle. Having cleared away this mass of diseased tissue it is now manifest that a few glands in the subclavicular fossa *are* involved, necessitating that the minor pectoral muscle be severed in order that this space may be thorougly cleared out. You can now see the vessels well exposed and free of all diseased glandular tissue. You also can now appreciate the necessity of severing the small pectoral muscle to obtain access to this region. The ends of this muscle will presently be sutured together. An opportunity is here afforded to demonstrate the well known surgical law: When operating in the neighborhood of important structures, always isolate and expose these structures. In this way their integrity is more surely maintained. Before closing the wound I shall take particular care to ligate all blood vessels at all likely to cause any hemorrhage, thus insuring better union. In fact, one of the main features of Halsted's operation is careful attention to and ligation of bleeding vessels, which precaution we have endeavored to observe throughout the operation. We begin closing the incision along the arm with continuous sutures; then we cover as much raw surface as possible with flaps of skin. As this gap is not very large, I shall turn in a flap from above, believing this will give a better result than the Thiersch graft. We will now dress the wound with aseptic gauze, with which I generally obtain the best results. As a rule, I use iodoform gauze in my hospital cases, but I never powder the wound with iodoform, for I believe union is frequently interfered with by irritation set up by this agent. This patient, gentlemen, I think I can safely say, will make an uneventful recovery, and will probably be ready for discharge in ten days or two weeks. This case is one of the most favorable I have ever operated upon in the hospital, as regards the stage of the disease. Only too often do we meet with these unfortunates when the disease has so far advanced as to render operation either futile, or, at best, only affording temporary relief.

[This case was discharged eighteen days after operation, apparently cured.]

II.

ECTOPIC PREGNANCY; OPERATION; DEATH.

CASE OF DR. M. J. MAGRUDER.

On May 24 this patient was admitted to the hospital with the following history: Miss L., white, aged about 30 years, was first seen January 1, 1900, when she was found suffering from severe pains in lower abdomen, nausea, vomiting; pulse was weak; constipation marked. At this time patient said her menses were regular and denied possibility of pregnancy. These symptoms began to subside after three or four days, and at end of three weeks she resumed her work—that of factory girl. She continued well until middle of May. On May 23 patient was again seen. She was then extremely nauseated, vomiting brownish fluid, suffering from abdominal pain; pulse rapid and feeble; surface cold and clammy. Physical examination revealed an enlarged abdomen and indications pointed to pregnancy of seven or eight months. She then confessed to being pregnant, and acknowledged having felt life during the month of April but not since. The os was not dilated. She was stimulated and small doses of morphia administered to relieve pain and vomiting. The fetus being apparently dead, it was decided to empty the uterus. On attempting to dilate, the external os readily yielded, but as the internal os was approached it was found rigid and unyielding. Finally a finger was introduced through the internal os, and with the hand thus well within the vagina the knuckles encountered a hard mass posteriorly and to the left. This mass was subsequently found to be a fetal head. The fundus of the uterus was outlined just above the pubis, slightly to the right. Diagnosis of extra-uterine pregnancy was established. Patient was removed to the hospital May 24, and on the following day operation was done by Drs. Fenner, Bloom and Magruder. Under chloroform anesthesia an incision was made through the posterior wall of the cervix; the fetal head was brought down and an attempt made to deliver the child with forceps, but failure attended every effort, though several kinds and styles of instruments were used. The head was then crushed and the fetus removed through the incision; the cord was tied and placenta allowed to remain. The cavity was washed out and packed with iodoform gauze. Infusion of normal

saline solution was practiced. Patient was removed from operating table profoundly shocked, and died from septicemia on the fourth day after operation. Apparently the condition was that of tubal pregnancy, the tube having ruptured in January and occasioned the symptoms above mentioned.

HUCHARD'S PILLS FOR JAUNDICE.—The *Riforma Medica* gives the formula as follows:

℞ Resin of podophyllum
Extract of hyoscyamus } .....each, 4½ grs.
Medicinal soap
Extract of rhubarb.....15 grs.
M. Ft. massa in pill. No. X div.
Sig.: One or two daily.

—*N. Y. Medical Journal.*

KAISERLING SOLUTION FOR THE PRESERVATION OF SPECIMENS:—

No. 1.

Aq. dest	1000 parts.
Formalin	750 parts.
Potassii nitras	10 parts.

No. 2.

Alcohol

No. 3.

Aq. dest	500 parts.
Glycerin	500 parts.
Potassii acetas	30 parts.

Directions—First place specimen into solution No. 1, allow to remain for 24 or 36 hours; then transfer to No. 2 (alcohol of 96 per cent.), and allow to remain 12 or 24 hours. Specimen can then be placed in solution No. 3 to remain permanently. By the above method no discoloration takes place, nor is the specimen in any way altered by the preserving fluids.—*Cin. Lancet-Clinic.*

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE ENDOWMENT OF MEDICAL COLLEGES.

Twice in the past few weeks this theme has been fully and ably discussed by two well-known medical educators and eminent men. Dr. Keen made this the subject of his annual address before the American Medical Association. In a large measure a comparison was drawn between the medical schools of the United States and those of Europe, now established many decades and under the autocracy of governmental power.

This discussion is timely, but needs to be reviewed from other points of view than those touched upon. More than two-thirds of the medical colleges in the United States were organized and are yet conducted as private enterprises, and the competition is in large degree aimed at numeric increase in students and a consequent increment of income. We annually see the effort against these as evidenced by a very few colleges organized and aiming for a higher education of the men licensed to practice the art of medicine.

The plea of discrimination dictates, before the endowments fall, that the public should know where the deserving colleges are located.

Some States, notably Michigan and Texas, practically afford a medical education (or any university education) gratis, and include in such a free gift the facilities of laboratory and other modern opportunities. The only requirement is that educational qualifications must be complied with and that the standard must be attained to qualify. Yet dozens of schools, far less accessible, enroll numbers of students willing to pay for much inferior advantages, but at institutions where the standard is governed by the profit and is discounted by the necessities.

State legislation is not all-sufficient, and the time has come when the medical profession as a whole should deserve such endowment for their schools as other kinds of institutions obtain, usually because they merit them.

The pace which modern advance has set is entirely too rapid for the provincial schools of medicine, planned as we have said for profit chiefly, and sooner or later these must fall by the wayside, as they should. There may have been need of them at some time twenty-five years ago, but now there are enough of the best schools to provide all the doctors needed for a few years to come.

We are heartily in accord with the appeal for the endowment of medical colleges at the hands of the State or at the munificence of private philanthropy, but we are convinced that discrimination alone may save harm and accomplish good. Let only those schools enjoy such benefit as may deserve it from their demonstrated good management, high standard and public interest for the public welfare.

TEACH PHYSIOLOGIC TRUTHS.

With the increased precision in diagnosis of to-day, obtained by improved instruments and additional scientific knowledge especially in microscopy and bacteriology, while sanitary science is acknowledged to be of prime importance, sufficient stress is not laid upon a proper observance of physiologic laws for the prevention of disease. The physician does not teach enough; in fact, he does not even think enough to be able to teach properly. As an illustration, take the sexual functions: how much mental anguish and physical suffering result from the fact that as children, as adolescents, even as parents, people are left untaught as to the proper rules to observe and the penalties incurred for their non-observance!

Human beings are left in utter ignorance as to the laws of the highest of all functions, that of reproduction. Young men and young women are expected to remain moral and healthy simply because it is supposed they may remain ignorant as to means of becoming vicious and diseased. With the women, who are inherently and naturally better and who have some safeguards thrown

...hat makes
t... ...s this regard!

The ... lies in gre... part with the medical profession. Let us take every opportunity to correct the wrong impressions that so generally exist concerning sexual and other physiologic questions. Let us do so systematically, by lectures and writings at schools and colleges. Let us do it whenever the opportunity presents, at patients' homes and in our offices. It will take time to undo the evil of generations, but fortunately the good seed also grows, if not as fast as the bad.

A New Method [illegible]

Operation.—R. Kossman, of Ber[illegible], Nov. 23, 1900, proposes a method, which may be described as a substitute for the rubber gloves. It is, more correctly speaking, a very thin, yet accurately, fitting glove, since it is a really impervious covering applied to the hands by soaking them in a substance which quickly dries by evaporation, leaving a smooth, flexible, yet sufficiently durable, coating, as thoroughly protective as any rubber glove can be, without its disadvantages. It remains only for further experience of other surgeons to say whether the claims of the inventor shall be substantiated.

The material is a fluid holding in solution "certain hard resins and fatty oils in a mixture of easy-boiling ether and alcohol." The substance has been patented under the name Chirol, which name has also been protected by law. The fluid is applied to the hands by immersion after they have been first thoroughly cleansed and disinfected, and then well dried. In 2 to 3 minutes it is quite dry and the hands are covered over with a beautifully fitting glove. It is easily removed by soaking in spirit.

We sum up the following advantages of the plan:

It has all the advantages of the rubber glove without its objections; it is very thin, very soft and pliable, and therefore does not so much interfere with the sense of touch, and does not in any manner constrict or cramp the hand, and yet it is so resistent and adhesive that it will withstand the manipulations of the longest operation without flaking off; it takes no longer to apply than the ordinary glove, since it dries in about the

time it would take to get a well-fitting rubber glove on, and yet it is absolutely without stickiness; and finally it seems not to be at all irritating while on or in the subsequent taking off with the spirit.

It has a further advantage over the glove in that it may be just as easily applied to the prepared field of operation, protecting this and at the same time making it much easier to pick up the skin with the fingers.

Hands covered with this coating may without smarting or damage to the skin be washed in a 5 per cent. solution of formalin, which is not an inconsiderable advantage in disinfection.

A further recommendation is the employment of the material in the holding of post-mortem examinations or in doing anything which would be apt to infect the surgeon's or the accoucheur's hands. It ought to be found very useful in obstetrics.

Tendon Transplantation in the Treatment of Deformities of the Hand.—Townsend, in the *Medical News*, July 14, 1900, writes an interesting article on tendon transplantation in the treatment of deformities of the hand, a subject which has risen into prominence since Nicoladoni successfully attached both peronei to the tendo Achillis in a case of paralytic talipes calcaneus. Many results have been reported in operations on the feet, while but few cases have been published in which operations have been done for the relief of deformities of the hands. Townsend explains this partially by referring to the relative infrequency of poliomyelitis of the upper extremities, but he thinks there are many cases of drop-wrist or of distortion of the fingers and hand due to cerebral palsies of childhood or to poliomyelitis or cerebro-spinal meningitis, whose deformities, he thinks, might be done away with by operation. Other conditions suitable for the operation are contractures following cerebral lesions later in life, paralyses following injuries to nerves or severed muscles whose ends can not be found and united.

In place of tendon-transplantation, the terms tendon grafting, tendon-anastomosis, tendon suture and function-transference have been proposed, but the first mentioned is the one most used by authors.

Townsend gives the cases he has been able to collect from literature, some twelve in all, to which he adds three operated on by himself and two personally communicated by Drs. Gibney and Whitman, making seventeen cases in which the operation has been performed in the upper extremity alone. These cases demonstrate conclusively that very great benefit may be gotten by this method of operating. "The necessity of careful and thorough examination as to the condition of the various muscles prior to operation is a matter of considerable importance. We should ascertain whether they react to faradism and whether the reaction of degeneration is present or not. To get good results with restoration of function, it is advisable to suture only tendons that have power left, that is, if we expect these tendons to do any active work in the future. Of course, the tendon to which they are sutured is usually a paralyzed one, and the method of action is that the non-paralyzed shall do the work of the paralyzed one. Careful study of the various movements produced by the action of the muscles will tell us which tendons to transplant and to which they can be best attached."

In rare instances a paralyzed muscle might be transplanted in order merely to hold the hand or fingers in a better position without any hope of the restoration of function.

To close up the tendon sheaths is often very difficult and probably unnecessary, since if we get union *per primam* there will be no adhesion to interfere with the movements of the tendons.

All kinds of suture material have been used with success, but the unabsorbable seem rather to have the preference because the absorbable kinds are apt to give way before the tendons have firmly united.

The field is a very promising one and deserves to be better cultivated than it has heretofore been. Patients suffering of deformities should not be dismissed with the statement that nothing can be done, but an effort should be made to do something for them by calling to our aid this procedure of tendon transference.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans, La.

Infarcts of the Placenta.—The significance of placental infarcts is a subject which has been under discussion for many years. Various theories have been offered to explain their frequency and significance, but no study of the subject seems to be so conclusive as the recent publication of J. Whitridge Williams in the *American Journal of Obstetrics*. The article is based upon the microscopic examination of five hundred placentæ. His conclusions are as follows: 1. Infarcts measuring at least 1 *c. m.* in diameter were observed in 315 out of 500 consecutive placentas (63 per cent).

2. Smaller infarcts, many just visible to the naked eye, were observed in the great majority of cases, while microscopic examination revealed early stages of infarct formation in every full term placenta.

3. The primary cause of infarct formation in the great majority of cases is to be found in an endarteritis of the vessels of the chorionic villi.

4. The primary result of the endarteritis is coagulation necrosis of portions of the villi just beneath the syncytium, with subsequent formation of canalized fibrin (as the process becomes more marked, the syncytium likewise degenerates, and is converted into canalized fibrin, which is followed by coagulation of the blood in the intervillous spaces, which results in a matting together of larger or smaller groups of villi by masses of fibrin.

5. The part played by the decidua in the production of infarcts has been greatly overestimated by many observers; it is more than probable, in many cases at least, that the tissue which they designate as decidual is really fetal ectoderm.

6. Moderate degrees of infarct formation are not pathologic and exert no influence on the mother or fetus, and are to be regarded as a sign of senility of the placenta, analogous to the changes which take place in the villi of the chorion at an earlier period.

7. Marked infarct formation is not infrequently observed, and often results in the death or imperfect development of the fetus. It is usually associated with albuminuria on the part of the mother, though at present we can not account for the relationship between them.

8. Infarct formation is *not* particularly marked in cases of eclampsia, being usually observed only *in* those cases which were preceded by marked albuminuric symptoms.

9. There is no evidence in favor of the bacterial origin of infarcts.

A Contribution to the Treatment of Rupture of the Parturient Womb, with a Critical Review of the Vaginal Operation.—Wendel contributes to the *Medical Record*, May 26, 1900, a valuable article under the above title, and reports three interesting cases. He states that the most essential factor disposing to rupture is over retraction of the upper segment of the uterus with consequent excessive, and therefore dangerous thinning of the lower segment and cervix. The most frequent cause of the condition is pelvic obstruction, the milder forms of contraction predominating. There are various contributing causes, such as obesity, external violence, sacculation, retroflexed uteri, and congenital displacement of abdominal viscera. Very trivial causes are sometimes encountered, *e. g*,. rupture during sleep and cases following simple primary uterine inertia. The milder forms of pelvic contraction should be noted early in labor. The severer forms of contraction are detected early and readily, but the diagnosis of milder cases of general contraction can be made only by careful external and internal pelvimetry. Wendel states that if in spite of strong uterine contractions the head fails to descend, and frequent examinations of the abdomen prove that the upper segment continues to retract, as shown by the ring of Bandl and tension of the round ligaments during contraction (particularly if the Bandl ring becomes oblique, one or both poles near the navel, and one or both round ligaments remaining tense between pains), rupture may be expected if delivery is not speedily accomplished. Prompt and deep chloroform narcosis should be employed to stop contractions and retard further thinning. In mild cases the head presenting, forceps may be applied with greatest gentleness, but only by a skillful accoucheer.

There is no dividing line that can be determined between threatened and beginning rupture. Is it justifiable then to use forceps in high degrees of thinning? Koblank found that 10 of 80 cases of rupture were caused by forceps. Winckel and Schaeffer found that high forceps give worse results to mother. Two distinct rules are applicable to head presentations when rupture threatens.

1st. When thinning of the lower segment is slight and the round ligaments are tense only during contractions, deliver with forceps.

2nd. When Bandl's ring is very high or very oblique, and one or both of the round ligaments are tense between pains delivery should be effected by Cesarean section or craniotomy. The same rule holds good for version in head presentations, the hand being substituted for forceps. The rule of action in transverse presentations is simpler, for when the child is living this fact indicates that dangerous thinning has not yet occurred and version may be attempted with deep narcosis. When rupture has occurred delivery must be accomplished without increasing the injury. In head presentations with living fetus in utero prompt application of forceps may save the child without increasing the mother's dangers, provided that the os is completely dilated and no pelvic contraction exists. When the head remains in the uterus and the body has escaped, McLean argues that the danger of increasing the injury no longer exists, and recommends passing the hand along the child until a limb can be grasped, then rotate and deliver, instead of losing time by attempting to grasp the mobile head with forceps. A dead fetus would of course be delivered by perforation and craniocleasty. Spontaneous rupture with transverse presentation results almost invariably in fetal death. Embryotomy would therefore take precedence when the fetus remained either entirely or in greater part in the uterus. If rupture occurs during version the operator must judge whether he had better continue or not; in general the child should have a chance for life. When the child escapes entirely into the peritoneal cavity, the conjugate diameter measuring less than 8 *c.m.* abdominal section will be necessary.

The author speaks at length upon the indications for and the repair of the uterus and care of the mother after rupture.

Deparment of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Cardiac Murmurs without Lesions of the Orifices in Eruptive Fevers.—The murmurs that may appear in the course of the eruptive fevers have hardly been, so far, the subject of any particular study, and yet their frequent occurrence in these diseases should engage our attention, for they might create in the attendant's mind fears as to his prognosis which are by no means justifiable.

Dr. d'Anfreville has recently made a very interesting study of this question based upon two thousand cases observed at the isolation hospital of Aubervilliers, in the wards of Dr. Roger. Figures show that regarding scarlet fever murmurs occurred in the proportion of 35 per cent. in men, 60 per cent. in women, and regarding measles, 20 per cent. in men, 29 per cent. in women.

These murmurs are therefore frequent, and much more so in women, as all the an-organic murmurs in general. It is chiefly at the period of declination in scarlet fever that these murmurs are found and in those patients whose organism is debilitated.

The lesion of the orifices accounts for them and they have no effect as to the duration, course and termination of the disease.

They seem to arise from either a diminished tonicity of the heart or from a disorder in the special action of the nervous system on the heart brought about by toxins or a cardiac strain. It must be added that the duration of these murmurs varies very much. They persist during several weeks, but usually not more than fifteen days; sometimes they are very inconstant and last only for a few hours.

They disappear without cause and reappear shortly after, at times identical with, at times different from the former ones.—*Journ. de Médecine Interne*, June 10, 1900.

Black Tenias.—Up to the present time there was on record but a single case of so-called black tenia, observed in the case of

a man, an Anglo-American, of the United States, and which Dr. Laboullène (a noted French expert) had styled "*Tœnia nègre*" or "black tenia."

Dr. Fritz, of l'Isle-Adam, has had the occasion of meeting with a similar instance in another man, a Frenchman, suffering from tuberculosis. This patient had a stubborn diarrhea, which none of the drugs used—benzonapthol, betol, salol, bismuth salicylate, etc.—had checked. Bismuth sub-nitrate, taken in large doses, and during a long while, was the only drug that had brought about some relief. His attendants were inclined to believe that he had a case of intestinal tuberculosis, when Dr. Fritz, one day, upon examining the stools found in them very distinct proglottides, fully developed generative segments of a tenia. He gave the patient a dose of pelletiérin, which brought the worm out, head included. It was completely black, and Dr. Fritz attributed this abnormal color of the worm to the penetration into its body of the bismuth taken by the patient.

Now there appeared lately in the *Bulletin Médical* another case of black tenia, reported by Dr. André Collet. In this similar instance the patient also had tuberculosis, and had taken bismuth in large doses. Dr. Collet also attributes the black color of the worm to the absorption of the bismuth taken by the patient.

He had kept the worm and noticed that it gradually faded, so much so that one month later it had the usual color of tenias.

Black tenias are, therefore, but accidental freaks, and they happen to blacken just after the manner of the chimney sweeper or charcoal man.—*Journal de Médecine Interne*, June 10, 1900.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Tannoform.—"An effort to combine with the astringent action of tannic acid the antiseptic powers of formaldehyde has been put on the market under the name of tannoform. According

to Dworetzky (*St. Petersburg Med. Woch.*, XXIII, 307), it is a tasteless powder, insoluble in water, but soluble in alkaline media. In the bowels it is slowly broken up, liberating the formaldehyde and tannin."

Tannoform is of value not not only in atonic diarrheas, but also in acute catarrhs of the bowel; indeed, it seems of more value as an intestinal disinfectant than as an astringent. The dose is one-half to one grain three to six times a day.

Coto-Bark.—A remedy so old as to be almost forgotten is coto-bark and its active principle, cotoin. This drug twenty-five years ago established for itself a high reputation in all forms of intestinal complaints, but on account of the scarcity of coto-bark, has passed into undeserved oblivion.

Oberlach (*Centralb. f. inner, Med.*, March 10, 1900) says that cotoin is far from being astringent, but is an active vaso-dilator in the intestinal tract. In inflammations, whether acute or chronic, it is of value by increasing the nutrition of the mucous membrane and thus hastening the healing of the diseased organ. Of especial value is its combination with formaldehyde, which has recently been put on the market as "fortoin." Fortoin is almost insoluble in both water and alcohol, but dissolves with readiness in the presence of alkaline salts. Oberlach has found it very useful in a large number of intestinal disorders; flatulent diarrheas, acute gastro-enteritis, chronic enteritis and the diarrhea of phthisis—both in adults and children. The hyperemia caused by it often temporarily increases secretion, which washes out the bowel without the irritation of a purgative. The chief drawback to its use is the cost, which must necessarily remain high on account of the difficulty in obtaining coto-bark. The dose is 0.1—0.25 *gm.* three times a day.—*University Medical Magazine.*

The Pilocarpin Habit is noted in a curious case of an individual who some years ago began the use of morphin, to which he later added cocain, and finally also pilocarpin, which was followed half an hour later by an injection of two grains of morphin, and in another half hour by a grain of cocain. The victim is said to be both a physical and mental wreck.—*Merck's Archives.*

Pane's Antipneumonic Serum has been used by Dr. Antonio Fanoni in eighteen cases of pneumonia with but one death of a patient, seen first on the ninth day and in the pre-agonal state of the disease. In this case the injection of 40 *c.c.* was followed by a marked improvement of the general condition, and the impending death was delayed two days. Four of Dr. Fanoni's patients were children under three years of age, and all recovered in a few days. The doctor injects 40 *c.c.* of the serum daily, by which means he obtains a rapid lowering of the temperature and amelioration of all other symptoms.—*Merck's Archives.*

For Malarial Fevers.—Dr. D. Palmer Ross (*Journal of Tropical Medicine*, May), surgeon-general British Guiana, and formerly resident at Sierra Leone from 1885 to 1894, gives the following formulary:

Antipyrin Mixture—

Antipyrin	15 grains.
Carbolic acid and glycerin (1 in 20)	20 drops.
Chloric ether	20 drops.
Water	1 ounce.

Give this every hour for three hours when the temperature is over 103 deg. F.

In case of vomiting give two drachms every quarter of an hour for three hours.

N. B.—Should this medicine cause difficulty or shortness of breathing, this feeling will be overcome by a dose of brandy.

Fever Mixture—

Bicarbonate of potassium	10 grains.
Nitrate of potassium	10 grains.
Chloric ether	20 drops.
Carbolic acid and glycerin (1 in 20)	40 drops.
Water	1 ounce.

Give every three or four hours during fever and until temperature falls to 101 deg. F.

Quinin Mixture—

Quinin sulphate	10 grains.
Water	1 ounce.

Give when the temperature is 101 deg. F., and repeat every four hours, and so long as the temperature keeps below 102 deg. F.

Quinin Enema—

℞ Sulphate of quinin, finely powdered ..... 20 grains.
Water ..... 1 ounce.

Give this as an enema should the quinin mixture cause vomiting, and repeat every six hours as above. On no account add acid.

Arsenic Mixture—

℞ Fowler's solution of arsenic ..... 3 drops.
Acetate of potassium ..... 10 grains.
Water ..... 1 ounce.

Give this three times a day for a week after an attack of fever, or when free from fever if the urine is black or dark colored.

—*N. Y. Medical Journal.*

For Fetid Bronchitis. — *Progrès Médical* for June 16 ascribes the following to Parcellé:

℞ Neutral acetate of lead, Terpin ..... of each 2½ grains.
Dover's powder ..... 1½ grains.

M. For one pilule. From three to four daily for children of from eight to twelve years of age.

—*N. Y. Medical Journal.*

The Uses of Naphthol in Therapeutics.—The *Journal des Praticiens* of February 24, 1900, tells us that the French Codex of 1884 directed that a druggist should always dispense beta-naphthol. According to studies made by Maximowitch alpha-naphthol is three times as antiseptic as beta-naphthol, and only one-third as poisonous. Further than this, beta-naphthol is not infrequently badly borne by the stomach and produces a sensation of burning in this organ, and also irritates the mucous membrane of the mouth and pharynx. For this reason Maximowitch has employed alpha-naphthol exclusively. He finds that it is a very valuable intestinal antiseptic, and administers it nearly always in a solution of castor oil. This solution has the advantage that it moves the bowels as well as produces an antiseptic condition. The prescription or formula which he employs is as follows:

℞ Naphthol alpha ..... 45 grains;
Peppermint water ..... 1 drachm;
Chloroform ..... 10 minims;
Castor oil ..... enough to make 3 ounces.

From a dessertspoonful to a tablespoonful of this mixture may be given to a child of ten years.

Alpha-naphthol can also be administered in the form of tablets made up in the following manner:

℞ Naphthol alpha ..... 4 grains;
Extract of belladonna ..... ⅛ grain;
Extract of rhubarb ..... 1 grain;
Tincture of cinnamon ..... 2 drops.

Make into one tablet and give 4 to 6 of these a day.

—*The Therapeutic Gazette.*

THE TREATMENT OF THE RICKETS IN CHILDREN.—The *Journal de Médecine de Paris* tells us that Kassowitz has treated no less than 560 rachitic children by the administration of full doses of phosphorus in each twenty-four hours. He claims very rapid improvement, particularly in relation to the craniotabes; the deformity and other characteristic symptoms speedily disappear. Betz employed phosphorus in the form of a pomade. The following formula is used:

℞ Phosphorus ..... ½ grain
Codliver Oil ..... 3 ounces

Teaspoonful twice a day.

Or,

℞ Phosphorus ..... ½ grain
Oil of Sweet Almonds ..... 1 ounce
Powdered Gum Arabic ..... ½ ounce
Powdered Sugar ..... ½ ounce
Distilled Water ..... 1½ ounces

Shake well and give one to three tablespoonfuls per day.

—*The Therapeutic Gazette.*

[N. B. We think the quantity of powdered gum arabic can be reduced one-half in the above formula].

PULMONARY TUBERCULOSIS TREATED BY INTRAVENOUS INJECTIONS OF HETOL was studied in twenty-five selected cases of the disease by Dr. C. A. Ewald. The patients chosen were those whose condition was most favorable for the treatment in question. The injections, which were almost invariably into the median vein, were begun with 1 *mg.* (1-64 grn.) of the remedy, and were repeated at intervals of two days or so in gradually increasing strength until a maximum of 15 *mg.* (¼ grn.) was reached. The duration of the treatment varied from 18 to 316

days. In all, 461 injections were made without a single unfortunate result. The most generally observed result of the treatment was marked weariness and desire to sleep, so that in some instances it was difficult to induce patients to take food. The few exceptions to this rule are accounted for on the supposition of suggestion. Another effect of the injections, occasionally, but not generally observed, was a tendency to pulmonary hemorrhage. Temperature and night sweats seemed to be unaffected by the remedy. No particular change in the behavior of the bacilli was noted in any case. The author's conclusion is that the results of this treatment do not justify the claims of its originator, but that, as it seems to be harmless, it is worthy of further trial.—*Merck's Archives.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King, New Orleans.

Persistent Adenoids in a Woman Aged Forty-seven.—A case of this kind was seen at the London Throat Hospital by E. Furniss Potter. The patient came to the hospital complaining of impaired hearing, and stated that she had never been able to breathe properly through the nose. She presented the appearance of a chronic mouth-breather, and when examined with the post nasal mirror was found to have a tumor mass in the nosopharynx which obscured the view of the upper half of the septum and extended across the vault of the pharynx between the Eustachian tubes. When removed and examined microscopically the growth was found to be composed of adenoid tissue which had undergone some inflammatory change. The patient's hearing improved and nasal respiration was restored. The writer refers to the case reported by Luc, aged 54, and one reported by Solis Cohen, aged 70 years. These are extremely rare cases.—*Journal of Laryngology*, June, 1900.

Some Points in the Differential Diagnosis of Laryngeal Diphtheria in Childern.—Emil Mayer, of New York, reports three cases indicative of the difficulty sometimes experienced in recognizing diphtheria of the larynx in children when a laryngoscopic examination is not practicable.

In the first case the faucial tonsils were considerably enlarged and the family physician who first saw the child attributed the dyspnea and hoarseness of the voice to that cause and recommended tonsillotomy. The glands at angle of jaw were enlarged, but there was no elevation of temperature. A close examination of the throat revealed the fact that the dyspnea persisted even when the tonsils were held apart and was consequently due to obstruction lower down. Laryngoscopy was impossible. A swab was introduced into the larynx and a culture showed presence of the Klebs-Loeffler bacilli in abundance.

Case 2.—A boy 4 years of age came with a history of hoarseness of two months' duration with recently beginning dyspnea. There was much obstruction of inspiration and marked hoarseness without any cause of obstruction in the pharynx. The larynx could not be seen. A diagnosis of papilloma of the larynx was made from the history, but could not be confirmed, as the child did not appear again at the clinic.

The third case was that of a child 2½ years old who had inhaled into the trachea a gutta percha tip from a nasal atomizer. It was thought that the body had been swallowed as only slight embarrassment of the respiration was at first noticeable. This increased until prompt relief was demanded. The voice was clear, a culture taken from the laryngeal secretion was negative. Inhalation gave no relief, and tracheotomy was performed. The gutta percha tip was found firmly impacted in the trachea. Death occurred from asphyxia before relief could be given.

The author concludes from a review of these cases that it is necessary to make a very close examination, first to ascertain the location of the obstruction, and secondly its nature. In many cases the bacteriologic examination must be relied on to give us the desired information.—*N. Y. Eye and Ear Infirmary Report*, January, 1900.

Indications for Constitutional Treatment of Catarrhal Affections of the Upper Air Passages.—In a very able

article by Walter A. Wells, of Washington, on this subject, the author calls attention to the many subjective symptoms in the nose and throat that are dependent upon a general neurasthenic condition. In these cases the subjective phenomena are out of all proportion to the objective lesions. The nasal, pharyngeal or laryngeal troubles, though often real, are secondary and in great measure symptomatic. These parts in the neurasthenic subject are so sensitive to impressions that a very slight organic change will give rise to prominent symptomatic manifestations. The constitutional treatment here is by far the most important, and in the majority of cases alone necessary. Rest from intellectual work and withdrawal from all sources of undue excitement are very important, and a complete change of occupation and surroundings is often necessary where these are found to be factors in the causation of the condition.

Medical treatment is, as a rule, of less value, but certain drugs, as well as hygienic measures, give some relief. Among these are mentioned the glycero-phosphates, arsenic, nux vomica, electricity, massage, hydro-therapy and moderate physical exercise.—*Medical Record*, April 21, 1900.

Facial Paralysis as Complication of Acute Otitis Media.—William R. Murray, M. D., of Minneapolis, found among 258 cases of acute otitis media two cases complicated with paralysis of the facial nerve on the side corresponding to the ear affection. In these cases the paralysis came on during the course of the otitis and disappeared after subsidence of the acute symptoms and healing of the drums by proper treatment.

The anatomic position of the facial nerve in its passage through the fallopian canal accounts for its being affected by this disease. Incased in a bony canal, the thin walls of which alone protect it from exposure within the tympanum, and in which dehiscences sometimes exist, an inflammation of the tympanum may readily extend to the nerve sheath, and this becoming swollen from the inflammation or an exudate forms and presses upon the nerve filaments and paralysis results. This condition may clear up entirely or the lesion of the nerve become permanent and destroy its function.—*Archives of Otology*, February, 1900.

Ocular Findings in Cerebrospinal Meningitis.—The details of the ocular findings in 23 cases are given by chance. Most of these were studied during the second or third week of the disorder and under considerable difficulty as regards ophthalmoscopic examination. Slight conjunctival discharges were observed in 7 cases. Motor disturbances were: Internal squint of both eyes in 2 cases, complete ptosis of the left side in 1, complete mydriasis in 1, with slight contraction during convergence. Irregular degrees of dilatation of both eyes were observed in 6, and pin-point contraction in 3 cases. In no case was there cloudiness or other disturbance of the media, nor any disease of the iris, choroid or retina. In all the cases examined, there was congestion of the optic disc with some congestion of the choroid and retina. The optic nerve-heads were edematous and their surfaces and border lines blurred,

particular object of [illegible] without great effort. When the attempt is made to focus the attention upon some matter requiring concentrated thought the mind soon wanders, and it is only by great exertion of the will that it is brought back again to the subject under contemplation.

Closely allied to this condition of disturbed mental processes mentioned above, and possibly depending upon it, is mental inaptitude or backwardness in children. Comprehension seems obtuse and slow. Frequently this condition develops rather suddenly in a pupil who has previously had no trouble in keeping his place with his class, and is then accompanied by headache and other manifestations. The correction of an existing eye-strain changes all this. School work is done more easily, and frequently the child is wonderfully changed mentally and physically. Instances are common where a child is backward in his classes in school, simply because of the effort required to

see distinctly. By this it is not meant that vision is not distinct for all distances, but that clear vision is attained only through the continuous exertion of a great amount of nerve force—in fact, the possession of distinct "sharp" vision by a person is no evidence that his eyes are free from imperfections, and that they are not working hard to maintain good vision. In short, good vision does not mean "good eyes," although it is usually so considered by the laity.

Vertigo is a symptom frequently associated with vision. It may be the result of some marked muscular anomally, or more often due to a refractive fault. The vertigo may be transient and infrequent, or be very marked and persistent, so much as to suggest grave intracranial disease.

Probably the most frequent of all the results of eye strain in the various forms is seen in disturbances of the digestive apparatus. In so many instances has it been observed that a recurrence of the symptom follows the disuse of the glasses, or is the first evidence of the need of a change of glasses, that the fact of cause and effect is surely established, and it is abundantly demonstrated that very many cases of digestive derangement have their origin solely in the organs of vision.—*Journ. of the American Medical Association.*

Miscellaneous.

The Legal Prevention of Tuberculosis.*—"Ex-Judge Abram H. Dailey, a former President of the Medico-Legal Society, and a diligent student of the science of medical jurisprudence, when asked to send his views in reply to the following question:

What has been, in your opinion, the most notable advance in that branch of forensic medicine, with which you are familiar, during the nineteenth century?

replied as follows:

* Read before the Medico-Legal Society at its June session, 1900.

My answer is, that in my opinion, that which has prevented the inception and spread of disease, through sanitary laws, based upon a knowledge of the causes of disease and the removal of the same, is the most notable.

The whole civilized world is interested in that subject. Medical and legal minds have everywhere been directed to it. and through their efforts legislative action has been taken, and thereby all civilized people enjoy a sense of security against the ravages of contagious diseases that they have never before experienced. The future is sure to increase this safeguard.

Dr. Henry B. Baker, Secretary and General Executive Manager of the Michigan State Board of Health, of Lansing, Mich., in response to the same question, said:

The most notable advance in forensic medicine, in the nineteenth century, is the aid which the law gives to the restriction of that disease which causes most deaths.

One reason why this is true is because that disease which causes most deaths is now known to be a preventable disease. Another reason is that it destroys our people at the ages when, except for this disease, most of them are in the prime of life; most of them are at an age when the cost for their rearing and education is at its maximum; at least half of those who die of this disease are between the ages of twenty and forty-five years, when their value as wealth producers is greater than at any other period of age. This one preventable disease causes the deaths of more than one hundred thousand persons in the United States, in every year. Considering the fifty thousand between the ages of twenty and forty years, if we estimate their value as wealth producers as equal to that of an average slave before the war, ($1000), and considering the losses incident to the premature deaths of another fifty thousand persons, and incident to the long continued sickness from this disease, of the many thousands who finally recover enough to die of other diseases, it is a low estimate that this country loses thereby one hundred million dollars per year.

Without the aid of the law, the restriction of this most important disease can not be systematically and thoroughly entered upon; for this work, *notification of cases* must be required to be given to local health officials.

In 1893 the Michigan State Board of Health passed a resolution. "That hereafter, consumption (and other diseases due to the bacillus tuberculosis) shall be included in the official list of 'diseases dangerous to public health' referred to in the law requiring notice by householders and physicians to the local health officer as soon as such a disease is recognized." The requirement has not been fully complied with throughout the entire State, but there is reason to believe that partly in conse-

quence of this action the death rate from that disease in Michigan has been reduced by rather more than one-tenth, and that the sickness from that disease has been decreased by a larger proportion. The success which has followed the imperfect action in Michigan, and in other States and countries, is good ground for a continuance in the belief which prompted the action—the belief that tuberculosis is a disease which can be restricted as soon as beneficent laws for this purpose shall be fully operative.

The medical profession has in the past, with that great conservatism which seems to have been the inspiring thought of the medical mind of the nineteenth century, doubtless due to its methods of medical education in the American States, confined itself to the treatment of consumption.

It has been only very recently that a very few of the more courageous among medical men have declared publicly that consumption could be cured.

They have done this at the greatest risk, and as a rule have been denounced by their brethren as quacks and impostors.

Still, among the more advanced thinkers among medical men, the impression gains ground that it is a curable disease, while a majority of medical men to-day doubtless regard it as certainly in the class of diseases where preventative means are justifiable.

Advanced thinkers among medical men unite with great unanimity in declaring that it is infectious, and that the bacillus of tuberculosis is well determined, and certainly ascertained and known, but this belief is believed to be far from universal, even among medical men.

That it is a proper subject for legislation, for the use of all proper means to prevent or arrest its spread or increase, is now very generally conceded, and the Michigan legislation and the statistics from that State show that similar legislation in other States, and still more radical measures, might be of great public good, in arresting the alarming spread of "this scourge of the human race."

This brings the question directly into the domain of medical jurisprudence.

How far can legislation be of service in affecting or securing beneficent results to mankind, in diminishing the volume of the disease, or in arresting its terrible advances?

The question has become one of profound and intense interest. It is the uppermost question of the hour. The recent Congress of Tuberculosis in Italy, the great interest in London and in the American States, made it advisable, in the opinion of the officers of the Medico-Legal Society, to bring it into prominence, and the organization of the American Congress of Tuberculosis was formed, as the results of its opening sessions on this theme. Its work is regarded simply as an introduction to the scientific world of the discussion of the subjects introduced.

An organization was perfected and the collaboration of all who take an interest in the movement was solicited.

The 13th International Medical Congress, of Paris, 1900, while it has not classified tuberculosis as a section, will doubtless discuss the questions involved at its session next August. Delegates have been selected to lay before that body the result of the preliminary labors of this First American Congress of Tuberculosis, and this brochure is sent out as an invitation to all those who wish to unite in an effort to stay the ravages of this terrible disease."—CLARK BELL, advance sheet from *New York Medico-Legal Journal.*

AS OTHERS SEE IT.—" We have gone to some length in stating the startling conditions which have afflicted New Orleans the past winter and spring, because they show that first, small-pox may exist within the same city and same year in both a mild and a malignant form; and, second, that we may emphasize the fact that the conditions in Indiana and Indianapolis are not notably different from those in Louisiana and New Orleans.

Indianapolis is centrally located, with nearly a score of railroads entering her borders; her hospitals, with a capacity of some 300 beds, and outdoor clinics with a hundred patients daily, are sought by the poor and ignorant of outlying regions and towns. The city has provided no isolation hospital, and has no inhabitable pesthouse. Her city hospital is liable to infection at any time, although it holds no outdoor clinic. Small-pox is now constantly with us, and will doubtless remain with us as long as it is prevalent in our own and neighboring States. The city has been at the expense of quarantining nearly a score of habitations within the year. There have been forty-five cases

diagnosed since January 1, and some of these are now confined in the contagious disease pavilion in the City Hospital grounds, which has been used as a pesthouse. The city should erect at once an isolation ward near the hospital with rooms for ten or twelve patients, where they may be at once vaccinated and their cases studied, if doubtful. A pesthouse should be built to contain a score of patients. It need not be far removed from the hospital, for the hospital inmates and attendants and the immediate neighborhood may be made immune by vaccination and revaccination.

Furthermore, vaccination should be enforced in houses and localities where small-pox appears. This is now done in a way by the dispensary physicians, but not infrequently the virus has proved inert, or the cases have not been seen a second time, with the result that there were failures to take, and small-pox has broken out again in the same houses, or localities, where it was first found. Indianapolis is not as well protected against small-pox to-day as is Chicago or New York. The disease has been so mild the people have lost their fear of it. Physicians still confound it with chicken-pox, a disease of childhood. Only three or four cases of chicken-pox have been verified in Indianapolis in youth from 18 to 25 years of age, among hundreds of cases of that disease.

Finally we have the misinformed, the misguided, the intellectually benighted, the bull-headed and ignorant egoists and charlatans, and the jealous and ulteriorly interested groups of physicians in various portions of the State who have failed to study the literature of the disease in general, and, particularly, the special histories of the present mild epidemic as described by Welch, of Philadelphia; Probst, of Ohio; Hyde, of Chicago; Egan, of Illinois; Ferguson, of Indianapolis; Reynolds, of the Chicago Health Board, and the special papers issued by the United States government, and some, alas, who do not take, or do not read, the *Indiana Medical Journal*, which has recognized and treated the prevailing eruptive disorder prevalent over one-half of the United States as nothing more or less than small-pox and entirely controlled by vaccination and revaccination. Education and death, the virile and relentless destroyers of many evils, will, in good times, do away with the above groups of professional parasites, and vaccination will be

accepted by doctors and people as the prophylactic for small-pox, as nonchalantly as they prescribe and use sulphur for the itch.

To this end, the State, through its recent wise sanitary legislation, and the decision of the present Supreme Court, upholding the police power of the State Board of Health, including the right to keep children out of both public and private schools unless vaccinated, has rendered mighty aid. This day, June 20, 1900, the Supreme Court of Indiana overruled the petition for a rehearing in the case of Frank D. Blue vs. Fannie M. Beach and others, and Miss Beach, of Terre Haute, will not admit the little boy, Blue, into the public schools of that city next September, unless he is vaccinated, and has a certificate to that effect. Thus does the State, which expresses the righteousness of the people, uphold justice and come to the defense of science. The law should compel vaccination at birth, at school age, and on entering manhood, as in Germany. Vaccination should be persisted in by physicians on their own persons year after year until they are certainly immune. No doubt such a series of vaccinations would have protected Dr. J. D. Ketchem, of Tunnelton, near Bedford, Indiana, who died of small-pox at his home June 3, after unremitting attention on cases of small-pox for several months, according to recent press reports.

There will always be doubters and opponents, such as Dr. Happle, of Trenton, Tenn., a man given to writing extreme and bizarre papers, though elevated to the dignity of a trustee of the American Medical Association. His paper read at the Atlantic City meeting, claiming that the present epidemic in his locality is not small-pox, was promptly negatived by his near neighbors, and received no support by any competent discussant. The American Medical Association spoke in no uncertain voice on this subject at the Columbus meeting, and the sense and probity of its utterance has gone forth to the ends of the land, and will not be affected by the opposition of a few physicians who are either ignorant, incompetent or prejudicial, and who think the special manifestations of the epidemic in their locality should be typical of the entire clinical manifestation of the disease."—Editorial *Indiana Medical Journal* for July.

Medical News Items.

The New Orleans Polyclinic gives evidence of success in the recent additions to their faculty and their plans for the future.

The growing importance of the institution in the South and Southwest, and the increasing classes, determined the faculty to increase their number to an extent commensurate with the demand. The following well-known gentlemen of the profession in New Orleans are to be congratulated upon their elevation to professional distinction:

Dr. E. M. Dupaquier, elected to the chair of Clinical Therapeutics; Dr. John J. Archinard, elected to the chair on Clinical Microscopy and Bacteriology; Dr. H. S. Cocram, Clinical Gynecology; Dr. J. A. Storck, Diseases of the Digestive Apparatus; Dr. Felix Larue, Operative Surgery and Applied Anatomy and Dr. Otto Lerch, to the chair on Clinical Diagnosis. Besides these, Drs. E. A. Robin and Gordon King, for sometime lecturers in the Polyclinic, have been respectively promoted to be assistant professors on diseases of the Eye and on diseases of the Ear, Nose and Throat.

The Polyclinic has besides this purchased the N. O. Sanitarium, and has assumed charge of the N. O. Training School for Nurses in conjunction.

Many alterations are planned, and with this end in view the property adjoining the Sanitarium has been purchased. While under the direct management and auspices of the Polyclinic, the Sanitarium is intended to fulfil, as it has in the past, a place unique, in this regard, that it is an institution, the aim of which is to furnish the best accommodation and hospital service for the patient of any physician, and it is not in competition with him, as the patient must employ his own physician; and that it is nonsectarain. Ward facilities are projected under the new arrangement, where patients, who now abuse the Charity Hospital, may be cared for at a reasonable fee. Besides, the Polyclinic now feels that it has accommodations for the patients each year brought or sent by the student physicians of the school.

Dr. G. M. Magruder, U. S. M. H. S., has been ordered to assume charge of the New Orleans station.

The New Orleans College of Dentistry graduated three students at the close of their last session. There were thirty-one matriculants for the year.

The New Orleans College of Pharmacy has been recently organized, with the following faculty: Mr. Walter T. Taylor, professor of pharmacy; Dr. William Asher, professor of chemistry; Dr. J. A. Storck, professor of materia medica, botany and physiology. This school aims at offering advantages to night students, and most of the lectures will be given at night. The board of directors is composed of a number of prominent men in the pharmaceutic and medical world.

The first session will begin the latter part of October.

Dr. J. S. Stephens, of Natchitoches, La., has been appointed a member of the Louisiana State Board of Health.

Dr. F. M. Thornhill, of Arcadia, has been appointed a member of State Board of Medical Examiners and the Board is to be congratulated.

The Annual Meeting of the American Editors' Association convened at Atlantic City, June 4, and on the evening of this date the annual banquet was held at Hotel Dennis. Speeches were made and toasts responded to by Drs. Love, Senn, Wile, Culbertson, Stone, Hughes and a number of others.

At the business meeting of the Association held in the parlors of Hotel Dennis, Medical Journalism and its influence upon medical progress was generally discussed, and it was decided to make the business session a leading feature of next year's meeting.

The officers elected for the ensuing year are as follows: Dr. Alexander Stone, St. Paul, President; Dr. Chas. F. Taylor, Philladelphia, Vice President; Dr. S. W. Kelley, Cleveland, Treasurer, and Dr. O. F. Ball, St. Louis, Secretary. The next meeting of the Association will be held at St. Paul, in June, 1901.

The Tenth Annual Meeting of the American Electro-Therapeutic Association Will be Held on September 25, 26 and 27, 1900, at the Academy of Medicine, in New York city. The headquarters will be one block from the Academy, at the Hotel Bristol, corner of Fifth avenue and Forty-second street.

The chairman of the committee of arrangements is Robert Newman, M. D., 148 West Seventy-third street, New York city. The committee has made preliminary arrangements for the meeting for scientific and social pleasures, so that the members will be in continuous attendance from early in the morning until midnight, varying social pleasures with scientific matters.

The Mississippi Valley Medical Association will hold its twenty-sixth annual meeting at Asheville, N. C., Tuesday, Wednesday and Thursday, October 9, 10, 11, next, under the Presidency of Dr. Harold N. Moyer, of Chicago. At a meeting of the executive committee, held at Atlantic City, June 6, the following were chosen to deliver the annual addresses: Dr. I. N. Love, of St. Louis, the address in Medicine; Dr. C. A. Wheaton, of St. Paul, Minn., the address in Surgery. Negotiations are in progress by which the members of the Association may obtain a one-fare rate for the round trip for this meeting. The Southeastern Passenger Association has already granted this rate, and it is believed the Western and Central Passenger Associations will concur. Due notice of this will be sent later. Further information may be had of the Secretary, Dr. Henry E, Tuley, 111 West Kentucky street, Louisville, Ky.

The Pan-American Exposition has seen fit to entrust the care of the department of Ethnology and Archaeology to a practicing physician.

Many members of the medical profession are interested in the study of American Ethnology and Archaeology, and not a few have valuable collections of Indian relics and skeletons from Indian graves. Those not directly interested in this study are so circumstanced as to be aware of the hobbies of their neighbors and could doubtless furnish the address of collectors. Exhibits which represent study in some special line of American Ethnology and Archaeology will be particularly suitable and loans of collections are desired. Any physician interested should address A. L. Benedict, M. D., Supt. of Ethnology and Archaeology, Pan-American Exposition, Buffalo, N. Y.

International Congress of the Medical Press.—The meeting of this body in Paris, July 26 to 28, presents a program of much general interest to medical journalists. Almost every burning question is touched up in the list of subjects for dis-

cussion. The exchange list, gratis journals, the usefulness of journals in organization, indexes, illustrations and a number of other matters are included. The success of the Paris gathering should mean a great deal for the advance in medical journalism.

An Appendix to the 'International Directory of Laryngologists and Otologists,' compiled by Mr. Richard Lake, is in course of preparation. In it will be found corrections of names and addresses already given, an additional list of names addresses and received since publication, and an obituary list.

Considerable additions have been obtained for the foreign list, which will materially add to its value and completeness. The decision of the editors of the *Journal of Laryngology, Rhinology and Otology*, under whose auspices the directory is published, to allow no name to be inserted in the British list for which sanction has not been given in writing, at once explains some omissions and criticisms. The editors, whilst desirous of making the directory as complete as possible, consider it best to adhere to this course. It is, therefore, hoped that all engaged in the practice of laryngology, rhinology and otology will assist as far as possible in making this useful work complete, by sending in their names and addresses to the editor, International Directory of Laryngologists and Otologists, 129 Shaftesbury avenue, W. C., London, Eng.—*Journal of Laryngology, Rhinology and Otology*, April, 1900.

Wood's Reference Hand-Book of the Medical Sciences. —An elaborate prospectus of the new edition of this valued work gives the assurance of its entire revision. The list of collaborators ensures the cyclopedic character of the Hand-Book and the specimen pages show that no pains will be spared to make the volumes an artistic and typothetic success. The first volume is announced to appear about the middle of August.

Notice.—All Surgeons, Assistant Surgeons, Acting Assistant Surgeons or Contract Surgeons, and Hospital Stewards, who served in the Army or Navy of the late Confederate States, will please send their postoffice address to Deering J. Roberts, M. D., Secretary Surgeons' Association, C. S. A., Nashville, Tenn.

THE MEDICAL MIRROR, of St. Louis, offers $1000 in prizes for theses on tuberculosis in its various phases. The prizes are to be distributed as follows: $500, $200, $100 and four prizes of $50 each. Among those on the committee of award are: Drs. Osler, of Baltimore; Geo. F. Butler, of Chicago; Walter Wyman, of Washington and others. Entries close October 1, 1900, and the award is to be made January 1, 1901, giving the contestants two months in which to prepare their papers and to include clinic reports.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Manual of the Practice of Medicine, Prepared Especially for Students, Fifth Edition, Revised and Enlarged. By A. A. STEVENS, A. M., M. D. W. B. Saunders, Philadelphia, 1900.

This work serves as an outline of the Practice of Medicine, and is intended to be used in conjunction with observation at the bedside. Students preparing for graduation and hospital examinations will find it a reliable guide. It is not intended to replace the text-book, but is far superior to the quizz-compendium. The present edition contains many improvements. The chapter on Diseases of the Pancreas, the introductory chapter on Diseases of the Blood and of the Ductless Glands, and the articles on Appendicitis, Angina Pectoris, Aphasia, Myxedema, and Syringomyelia, have been entirely rewritten. New articles treating of Acute Cholecystitis, Tuberculosis of the Kidney, Gastroptosis, and Enteroptosis and Chronic Cerebral Leptomeningitis have been introduced. We consider the book the best of its kind.

It is bound in flexible cover, and the typographic work is good.

STORCK.

The Principles of Treatment and Their Application in Practical Medicine. By J. MITCHELL BRUCE, M. D., M. A., F. R. C. P. Adapted to the United States Pharmacopea, by E. QUIN THORNTON, M. D. Lea Brothers & Co., Philadelphia and New York, 1900.

This work of Dr. Bruce is to some extent a departure from the usual run of medical works. We have derived both pleasure and information from a perusal of this most interesting book.

The work is planned on the lines followed by the author, "both in the classroom and at the bedside, of directing the attention of students first and chiefly to the objects of treatment, which their study and observation of pathologic and clinical facts reveal to them; and thereafter, and not till then, of discussing the selection of medicinal and non-medicinal measures calculated to effect the desired ends."

Dr. Bruce deserves much praise for his admirable presentation of the subject in such an attractive form.

The book will well repay a careful reading. STORCK.

Practice of Medicine, a Manual for Students and Practitioners. By GEORGE E. MALSBARY, M. D. Lea Brothers, & Co., Philadelphia and New York, 1900.

This is another of those manuals, intended for students, standing between the text-book and the quiz compendium. The subjects are presented in a brief form, made readily accessible by a good index.

STORCK.

A Text-Book of Materia Medica, Therapeutics and Pharmacology. By GEORGE T. BUTLER, Ph. G., M. D. W. B. Saunders, Philadelphia, 1900.

It is with pleasure that we recommend this most excellent book. In our review of a former edition we spoke of some of its good qualities. It is without doubt one of the best single volume works on materia medica published, and deserves a large circulation. At the present day, with its abundance of bad medical works, it is refreshing to find so good a one as Dr. Butler's. STORCK.

Enlargement of the Prostate. By C. MANSELL MOULLIN, M. D., K. F. C. S. P. Blakiston's Son & Co., Philadelphia, 1899.

This is the second edition of a valuable monograph of 200 pages, treating of the prostate, the pathology, etiology and symptomatology of its hypertrophy, and the treatment of the latter, both palliative and radical, both by direct and indirect methods.

Some of the operations described in the previous edition have been omitted as being chiefly of historic value. The author has retained only those he considers of practical utiltty and has given a complete account of them, often in detail, comparing their merits and mapping out their indications.

The volume is useful to the practitioner as a guide in preventing mischief and to the surgeon or specialist as giving the opinion of an able operator. CHASSAIGNAC.

PUBLICATIONS RECEIVED.

Food for the Sick and How to Prepare It, by Edwin Charles French, M. D.—John P. Morton & Co., Louisville, 1900.

Fractures, by Carl Beck, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

Suggestions to Medical Writers, by George M. Gould, M. D.—The Philadelphia Medical Publishing Company, Philadelphia, 1900.

Diseases of the Eye, by Edward Nettleship, F. R. C. S.—Lea Bros & Co., Philadelphia and New York, 1900.

A Manual of Operative Surgery, by Lewis A. Stimson, M. D.—Lea Bros. & Co., Philadelphia, 1900.

Twenty-Third Annual Report of the Board of Health of the State of New Jersey, 1899—MacCrellish & Quigley, State Printers, Trenton, New Jersey, 1900.

Tenth Annual Report of the Eye, Ear, Nose and Throat Hospital, New Orleans, La., 1900.

Atlas and Epitome of Special Pathologic Histology, by Docent, Dr. Hermann Durck—W. B. Saunders, Philadelphia, 1900.

A Treatise on Appendicitis, by John B. Deaver, M. D.—P. Blakiston's Son & Co., Philadelphia, 1900.

Surgical Anatomy, by John B. Deaver, M. D.—P. Blakiston's Son & Co., Philadelphia, 1900.

The Science of Hypnotism, by L. W. De Laurence—Alhambra Book Company, Chicago, 1900.

A Manual of Clinical Diagnosis, by Charles E. Simon, M. D.—Lea Bros. & Co.. Philadelphia and New York, 1900.

A Manual of Surgical Treatment, by W. Watson Cheyne, M. B., and F. F. Burghard, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

"*Festschrift*," in honor of Abraham Jacobi, M. D., LL. D.—The Knickerbocker Press, New York, 1900.

A Dictionary of Medicine, by Alexander Duane, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR JUNE, 1900.

CAUSE.	White.....	Colored.....	Total.....
Fever, Malarial (unclassified)	4	5	9
" " Intermittent	.....	.....	.....
" " Remittent	2	2	4
" " Congestive	.....	3	3
" " Typho	.....	.....	.....
" Yellow	.....	.....	.....
" Typhoid or Enteric	13	4	17
" Puerperal	2	.....	2
Influenza	.....	.....	.....
Measles	1	.....	1
Diphtheria	2	.....	2
Whooping Cough	1	1	2
Apoplexy	11	9	20
Congestion of Brain	7	2	9
Meningitis	11	2	13
Pneumonia	16	7	23
Bronchitis	2	3	5
Cancer	6	5	11
Consumption	48	38	86
Bright's Disease (Nephritis)	20	14	34
Uremia	2	.....	2
Diarrhea (Enteritis)	25	11	36
Gastro-Enteritis	10	5	15
Dysentery	8	2	10
Hepatitis	3	.....	3
Hepatic Cirrhosis	3	1	4
Peritonitis	4	2	6
Debility, General	.....	4	4
" Senile	11	3	14
" Infantile	8	5	13
Heart, Diseases of	25	11	36
Tetanus, Idiopathic	.....	.....	.....
" Traumatic	4	3	7
Trismus Nascentium	2	9	11
Injuries	17	13	30
Suicide	6	1	7
All Other Causes	141	118	259
TOTAL	415	283	698

Still-born Children—White, 7; colored, 14; total, 21.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 23.71; colored, 37.73; total, 27.92.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	29.90
Mean temperature	80.
Total precipitation, inches	5.10

Prevailing direction of wind, south.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. SEPTEMBER, 1900. No. 3.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for thi department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

VARIOLA—ITS SYMPTOMATOLOGY, COMPLICATIONS, DIAGNOSIS AND TREATMENT, AS LEARNED FROM THE STUDY OF 100 CASES SEEN AT THE SHREVEPORT PEST-HOUSE, IN JANUARY AND FEBRUARY, 1900.

BY S. C. BARROW, M. S., SHREVEPORT, LA.

DEFINITION.—Variola is both an infectious and contagious febrile disease characterized by an eruption which, *without* treatment, passes through the successive stages of macule, papule, vesicle, pustule and desquamation.

I would call attention to two points in this definition: first, the fever is emphasized as being a constant factor. Secondly, the phrase "without treatment" implies that *with* treatment the disease can be made to pursue a milder course. These are two facts which I think must necessarily appear in a correct definition of small-pox.

SYMPTOMATOLOGY.—Most often the first indication of small-pox is seen within 15 days after exposure. Every case that developed at the suspect house during my service, incubated between 10 and 15 days with the exception of three, and these gave a history of just 20 days between last exposure and the first elevation of temperature.

Of all the many symptoms enumerated as accompanying an attack of variola, the fever temperature and eruption are the only ones that may be termed constant.

Drs. Tyson, Osler, Anders, Strumpel and Flint, all agree that the onset is sudden with a violent chill. This is not my experience.

Out of the 100 cases noted by myself at the pesthouse only 23 gave a history of a distinct chill, 52 noticed only chilly sensations, while the remaining 25 had no symptoms prior to the eruption aside from fever, slight headache and sore throat. Fever is always present, when following a chill it is usually high. Hand in hand with elevated temperature we find most often head and backache, the former more often than the latter.

Nausea and vomiting are *not* constant symptoms, occurring in only 11 of 100.

When present they are usually indicative of a severe attack, four out of these eleven cases having been confluent, six semi-confluent and one hemorrhagic. Prostration, when present, from the onset is another precursor of evil. Out of the thirty confluent cases, twenty-four showed great prostration from the beginning; of the four hemorrhagic, all. Another and most constant symptom prior to the eruption is a pharyngitis. I have seen this in fully 90 per cent. of cases from the mild discrete to the hemorrhagic types. Most often the pharyngitis is present from the beginning, becoming more aggravated as the case develops, or it may be delayed as late as the pustular stage.

Usually at this stage the tongue is of a bright pink color unless there are complications. The pulse most often is in proportion to the degree of fever. There is commonly anorexia and constipation.

From the foregoing the peculiarity to be noted is the extreme mildness with which a case of variola vera may have its onset.

The violent chill followed by extremely high fever, with intense head and backache; marked prostration; nausea and vomiting, may all be absent, and we will find the true variolous eruption succeeding a train of symptoms which pointed simply to a mild attack of malaria.

Eruption.—The rashes spoken of as appearing on the second day I have never seen, as all of our suspect cases were negroes. In a great majority of cases the true eruption makes its appear-

ance on the evening of the third day; not most often upon the forehead, along the borders of the hairy scalp and taking a regular downward progression, as we learn from most writers, but upon the anterior portions of the cheeks first, then to other parts of the face, pursuing a very irregular course as it spreads to other parts of the body.

Coincident with its first appearance upon the cheeks, the soft palate and buccal mucous membrame are often found invaded.

For the first 24 or 36 hours the eruption resembles very much that of measles, being of a slightly pinkish red color and undistinguishable by palpation. By the end of the next 12 or 24 hours we have developed the perfect papule which can be distinguished both by inspection and palpation. The papules are usually about the size of a No. 10 bird shot. The common comparison, "shotty," is very expressive. It feels like a distinctly foreign body imbedded beneath the skin, and is slightly movable.

There is not always the decided drop in temperature on the first appearance of the eruption, though there is often a decline of a degree or degree and a half. The following is a fair example of a large percentage of the temperature records which I have seen: Case No. 50, female, age 21 years; diagnosis hemorrhagic small-pox. Onset of disease, January 16, no chill; great nausea and vomiting, pains in head, back and limbs; prostration marked; temperature 103 deg. F.; January 17, temp. 102 deg.; 18th, 103 deg.; 19th, 103 deg.; 20th, 103 3-5 deg.; 21st, 104 deg.; 22d, 103 deg.; 23d, 102 deg. This shows at the end of the eighth day only a decline of one degree from the first elevation, while on the fifth day, the second day of the eruption, the temperature was one degree above the first elevation. In those cases where a decline in temperature is noted, it usually comes on about the sixth or seventh day; the time at which the entire eruption had made its appearance, unless a secondary fever temperature appears. There are no portions of the integument exempt from the eruption through the areas covered by the initial rashes spoken of, such as the abdomen, the inner anterior upper portion of the thigh, the axilla, etc., are usually only slightly affected. I have seen the eruption confluent upon the glans penis. The nipples are sometimes affected, while again the cornea may receive a

pustule or so resulting in loss of sight. By the sixth day the papules become vesicular, and about the eighth the vescules become pustules. This is the stage at which we meet the secondary fever, though it rarely occurs excepting in severe confluent cases.

Complications.—The most constant complication met is abscesses; these at times become so large and numerous that they are dangerous in themselves. Fifty per cent. of the cases treated at the pesthouse during this epidemic suffered with abscesses of unusual size and numbers, while nearly all of the remainder had them to a greater or less extent.

Parotitis occurred only once, while otitis media and cellulitis with edema of penis and scrotum was seen in two cases. In women menorrhagia and metrorrhagia are sometimes troublesome, in children diarrhea is frequent. Prolonged delirium resulting in insanity before death occurred in one case. Conjunctivitis is very common.

Diagnosis.—A positive and correct diagnosis can not be made prior to the appearance of the papules, but on their development, coupled with a clear history of the case, all doubts cease. However, if seen for the first time in the maculo-papular or in the pustulo-desquamating stages, it may be confounded with other eruptive diseases.

I believe it is impossible to differentiate small-pox prior to the eruption from a case of remittent malarial fever unless by a microscopic examination of the blood. In order to show how naturally the two may be confounded I give here the following notes on two cases treated at the Charity Hospital:

Case 1.—Negro, age about 20, came to hospital near first of December, 1899. Gave history of a chilly sensation morning of same day followed by fever; temperature then about 102 or 103, pulse in proportion; complained of head and backache and achy sensations over whole body. He was sent to the ward and placed upon anti-malarial treatment; malarial fever being the diagnosis. His temperature remained at about the same height, until the night of the third day, the second, in the hospital, when an eruption appeared which proved to be that of small-pox.

Case 2. Strong robust negro aged about 25 or 30. Had chill day before entering hospital, temperature then quite high;

intense headache and muscular pains, especially in back; sore throat, nausea and vomiting; history of exposure to small-pox.

Patient was isolated and watched for two days, no treatment being given but anodynes and antipyretics. At the end of this time, his symptoms remained unabated, when he was given quinin. His fever yielded, his aches subsided and in a few days he was discharged from the hospital cured.

I would call attention to the severity of the symptoms in the second case contrasted with those of the first, from which it will be seen a differential diagnosis is impossible.

In the maculo-papular stage variola resembles to a certain extent rubeola. In typical cases of the two diseases, there is no room for confusion, but in anomalous types it is hard to separate the two.

In an epidemic of measles it is to be remembered that infants and children are the ones mostly seized, while in small-pox, from the greater exposure, adults and especially men give a larger percentage. In measles the attack is generally less severe in children than with adults, while in small-pox the reverse is true. The history of exposure will of course aid in a diagnosis. The manner of onset, the presence of the catarrhal symptoms of the upper air passages, together with redness of eyes and photophobia at the beginning of measles, are symptoms not seen in small-pox in the early stages. Between the two eruptions differences can also be found. The macules of measles are more blotchy than in small-pox; they are generally confluent and of a purplish pink color, while in small-pox we rarely find confluence so early, and the macules present an active rather than a passive hyperemia. The increase in fever temperature in measles on the appearance of the eruption is reversed in small-pox sometimes, as was noted. Again it will be noticed that the macules of measles show a greater elevation on inspection than can be demonstrated by touch, while in the variolous macule the elevation is not exaggerated.

When seen for the first time in the pustular or desquamating stage, small-pox is often confounded with syphilis. Under such circumstances the early history of the case is necessary. Variola being an acute disease, many of the early symptoms, such as chill, high fever, nausea, vomiting and prostration, have not been present if the case is syphilis, while the pharyngitis,

headache and other symptoms found in each disease are generally more acute and intense in variola than in syphilis.

While the small-pox eruption may show itself in many forms, that of syphilis is more often polymorphous. Again, the latter is distinctly symmetric, while variola is not always so. It is said that the syphilides always appear in crops when of the small and shotty size, describing circulets, which can be easily traced as they merge into each other, forming crescents of varying size; no such regularity can be found in a variolous eruption as it appears indiscretionately on all areas. Finally the history of chancre with enlargement of lymphatics, alopecia, etc., seal the diagnosis of syphilis, unless the two diseases exist together, when we can usually find two distinct eruptions and a history for each.

The Treatment outlined below is the one practiced by Dr. J. F. O'Leary, physician in charge of the pesthouse. This may be considered under the two heads, systemic and local. It is only occasionally the case that we meet a physician or encounter a writer whose treatment of small-pox is anything but local and symptomatic. They all argue that variola is a self-limited disease.

I have seen it aborted or at least the confluent arrested at the semi-confluent stage, the semi-confluent at the discrete, etc.

In order to reach this successful end, the growth of the papule must be arrested, and to do this its supply of nutrition must be stopped. Hence as all processes, pathologic and physiologic, receive the nutrition necessary to their growth from the blood, we can stimulate their growth by increasing the amount of blood to the part, or retard it by decreasing it.

The pathology of the small-pox eruption being primarily a localized inflammation, with a consequent necrosis of the inner layer of the epidermis and true skin, caused, most probably, by the presence of a parasite, the rational treatment must lie in an antitoxin or in depriving the papule of its nutrition. But, as the nature of this parasite is not known, nor yet the antitoxin determined, our treatment must be directed mainly towards limiting the supply of blood to the periphery. For this purpose cocain and ergot seem to be the drugs *par excellence*. Cocain hydrochlorate gr. ¼–½, and fluid extract of ergot ʒss every three or four hours, will contract the arterioles, decrease

the number and strength of the heart beats and thus bring about an anemia of the skin and subcutaneous structures. The eruption is then seen to become less hyperemic; the growth is checked, and what otherwise would have been a confluent case is stopped, at least, at the semi-confluent stage. The two drugs seem to act better together than alone. I call to mind two cases which promised in the beginning to become confluent, one received cocain alone, the other cocain and ergot; the former developed a severe discrete type, which passed through the regular course to scab, while the latter had only a discrete type, the eruptions drying out before reaching the pustular stage. These cases are but examples of the great majority I witnessed while at the pesthouse, and compared with those whom I have seen that did not receive this treatment early, I think it can not be gainsaid that the drugs mentioned did the work. Two other indications which cocain seems to meet are relief from itching and from nausea. Added to the above, protonuclein seems to be a valuable remedy. Being one of the constituents of cell life, a promoter of leukocytosis and a germicide, its indication in small-pox is very plain. Given in 10 grain doses every 3 or 4 hours, it acts also as an appetizer, and the routine nourishment so necessary in hospital practice is always taken with relish. With the above systemic treatment, the local becomes less imperative. A boracic acid wash for the eyes and nose will most generally keep them clean, while a 25 per cent. solution of peroxide of hydrogen used as a gargle will relieve the sore throat which is often so troublesome. As soon as the eruption becomes pustular the pustules should be freely opened, mopped out with an antiseptic solution and dusted with an absorbing powder, such as bismuth, aristol, boracic acid, lycopodium, etc.

For the abscesses, early and free incisions, bichloride of mercury irrigation and drainage generally cures. Of course symptoms are to be met; the bowels should be opened daily with warm water enema. Purgatives are inadmissible unless given at the beginning, when a cholagogue will do good. A weak and rapid heart needs digitalis, while a slow and feeble pulse should be met with strychnin.

In regard to the diet, solids are not to be considered; the patient should be kept up on an easily digested and nutritious

diet until he has fully scaled off, and then solids should be approached gradually and with caution.

A SYNOPSIS of the above cases:

Number of cases		100
Confluent	30	
Semi-confluent	12	
Hemorrhagic	4	
Severe discrete	45	
Mild discrete and varioloid	9	
Adult males	69	
Adult females	22	
Children (under 10)	9	
Number of deaths		11
Males	5	
Females	4	
Children	2	

P. S.—In collecting the notes on the above cases, I am specially indebted to Dr. J. F. O'Leary for his appreciated suggestions, and many kindnesses extended me while in service at the pesthouse.

SUCCESSFUL TREATMENT OF VARIOLA.*

BY V. LEHMANN, M. D., HAHNVILLE P. O., LA.

Meeting with so much diversity of opinion in the treatment of small-pox, when called upon to act in the capacity of health officer during the year 1896, nineteen cases scattered throughout my parish of St. Charles being thus thrust into my path found me somewhat at a loss to make a choice among the abundance of means lauded in favor of its treatment, when the following method appeared among others to offer the more encouraging advantages as confirmed by the results obtained.

During the prevalence of the disease, a fever characterized by pain in the loins subsiding on the appearance of an eruption on the face, especially the forehead, leads us really into its diagnosis. If excessive, the fever is easily mitigated by the exhibition of

* Read before the Louisiana Medical Society, April, 1900.

those antiseptic agents known among so many others to be the less likely to cause a depression in a system already overwhelmed by the virulence of the poison. As soon as we have obtained this condition, a medium dose of calomel and soda, followed in about four to six hours by castor oil, by the cleansing up effect on the *naturales viae*, helps the course of treatment. When not confluent, encircling each spot of the eruption by means of a fine camel hair-brush with a slight coating of tincture of iodin, limits the extent of tissue involved in the suppuration and consequent deepness of the following cicatrices, after which the whole surface is protected from the irritating contact of the air by being smeared with some soothing and antiseptic ointment, such as vaselin. As food and drink, cooled scalded milk, having a quieting effect, is provided *ad libitum*, giving thereby sufficient nourishment to the system of the patient without overtaxing his nervous power. The disease being above all of a bacterial and excessively depressive nature, leads us to cope with it successfully with the exhibition of such agents as may give us the best chance of counteracting its effects, in other words, of remedies both non-excitably tonic and germicidal, although long known to my brother practitioners, which may not in the combination proven to be so serviceable as set forth in this short paper have been used by some among them; hence to the latter is here cordially offered the benefit of my very small experience, which resumes itself in the handling of these above mentioned nineteen cases, all colored, under trying circumstances, very unhealthy surroundings, most limited hygienic means at my command, with results so gratifying as to far exceed my expectations.

It having come to my notice through the daily press that the eminent Dr. Bedford Brown, of Alexandria, was successful in the treatment of an epidemic of the disease being then prevalent at his place, by means of the internal use of the tincture of chloride of iron, I beheld with pleasure the evident adaptability to the disease of this special medicinal agent as being *the combined* tonic from its feruginous and germicidal—from its chlorine—properties *par excellence*. From this valuable idea my attention was led to another well-known agent, fully tested and recommended as a prophylactic in all zymotic diseases by my ever dearly esteemed Prof. John Barnwell Elliot, of Tulane University, and to my mind relatively curative, also superiorly ger-

micidal in its sulphurous and alkalinizing nature, besides counteracting the astringent and heating effect of the tincture of iron by its laxative and cooling febrifugal properties, the sulphite of sodium, thus forming together a most happy combination, which was administered by dissolving one ounce of the sodium sulphite in a quart of water, adding thereto one ounce of the tincture of iron and giving one tablespoonful three times daily, with a five-grain capsule of sulphate of quinin, also tonic, germicidal and febrifugal, the whole leading to a prompt and decided recovery, with increased recuperated strength, normal activity in the functions of all the organs, plumpness of the body and a general well being, confessedly unknown before the sickness, of the usual unsolicited statement of the patient.

IMPROVED METHOD OF VACCINATION—VACCINOID.*

By V. LEHMANN, M. D.

Being impressed from a close observation of the usual method of vaccination in vogue with the too frequent untoward sequelæ not only immediate in the severe illness following ordinary vaccination, but permanent in the plastic deformity inflicted on the persons of our Maker's greatest gift, our dear women, my attention drawn to a careful study of the subject was rewarded with the following gratifying results which I feel it my bounden duty to humbly offer my professional brethren *pro bono publico.*

Before the vaccine points were extant the ordinary mode of vaccination, as you gentlemen well know, first consisted into slashing sideways through skin and muscle a lancet to make space for the introduction of a scab originally taken from the cow's udder and then transmitted from one person to another. Lucky was he who chanced to escape the unsuspected inoculation into his system of some such poison as syphilis through the medium of the scab used for vaccination originating sometimes in one constitutionally afflicted with the above-mentioned or with any of the other highly contagious loathsome diseases. Then came the murderously pronged vaccinating comb and its allied congeners vieing with each other for the more effective results in the comparative hugeness of their ap-

---

* Read before the Louisiana State Medical Society, April, 1900.

pearance, seeming, as it were, to be the impression then latent in the minds of many, that the deeper, more extensive and colossal the vaccination, the more effective and protective the result. Gray tells us (Ed. 1883, p. 94), that the lymphatic or absorbent vessels of the skin are arranged in a minute plexiform network in the superficial layers of the corium. Hence the simple exposure of a small portion of the derma to the vaccine virus by the careful removal of the epidermis is amply sufficient to obtain the desired result.

The advantages of the technic here claimed lie during the vaccination in the total absence from all pain, unless scarifying and undesirable bleeding are practiced; the first being an incentive to vaccination, the second avoiding unnecessary large size with proportionate enormity of resultant sore, and the third preventing the vaccine from being possibly washed away by the outflowing blood.

If performed on the outside of the arm, as most universally usual, the latter is seized gently with the hand, holding it between the thumb and index, the surface being made tense by gradually pulling it apart; the vaccine point is then applied giving it a to and fro, rapid and steady motion not extending beyond the eighth of an inch, barely touching the skin during the first five seconds, a little heavier next five seconds and so only by degrees until the spot, as it were, hypnotized or rendered anesthetic by this localized persistent and gradually increasing friction, is made bare of its cuticle and the two sides of the vaccine point previously moistened with rain water to loosen from them the bovin virus are passed over the denuded minute area causing the virus to change place from the surface of the point to the surface of the exposed derma. The next step is to protect the seat of the operation from future disturbance; that is, to prevent the vaccine being rubbed off through the clothing by means of a bit of tissue paper thereon applied and held in place until dry, at which time remains no further possibility of trouble. Other precautions to be practically followed in order to be spared the unnecessary difficulties too often experienced by many unfortunately ignorant victims in the sequelae of vaccination, such as alarmingly inflamed arms to the extent of causing the people to be almost in dread about possible amputation, is the nursing of the vaccinated area as follows:

1. Minimizing all undue irritation from friction of the clothing by applying a light bandage of muslin or linen around the arm.

2. When inflamed and approaching maturity, soothing ointments as vaselin, cold-cream, carbolized oil, etc., will be of some service.

3. Absolute rest to the arm by avoidance of all physical exertion.

4. Removal of other indirect sources of irritation, such as hyperacidity of the blood and auto-infection from the digestive tract by means of a mild saline purgative, and such foods and drinks as hygiene dictates should be used to keep the body as healthy as possible.

With the above hints faithfully carried to execution there is no possible cause for any trouble whatsoever to those undergoing the process of vaccination, as experienced through thousands of cases under my immediate care during my term of office while health officer of the parish of St. Charles.

VACCINOID—In connection with vaccination, I beg to invite the Society's attention to a subject somewhat interesting and worth the while to be carefully noted in our so-far only one test to the immunization of variola in the words commonly used in reference thereto, that is: *the take or no take of vaccination* is "*Vaccinoid,*" the aborted vaccination which we consider to have the exact same relation to the successful vaccination as varioloid, the aborted variola, has to the fully developed variola, absolutely the same condition with the only difference of a question of degree in the development. Hence, a vaccination followed by a mere reddening of the spot with elevated surface presenting the appearance of a proliferation of papillae with no exudation of secretion whatever but remaining a dry and raised spot for some time to come, as a soft and hyperlastic growth may be accepted, we are satisfied, as a final test of immunization of the person to the vaccine or cow-pox and hence to the variola or small-pox, the said condition being as a rule met with in persons having undergone previous vaccination within a few years, or to that extent naturally immune to the poison.

SUGGESTIONS FOR THE TREATMENT OF GASTRO-INTESTINAL AILMENTS OF CHILDREN.

BY B. A. COLOMB, M. D., UNION, LA.

Sub-acute or chronic indigection, with several stools daily; loose and containing undigested aliment; perhaps foul smelling. The indications are, *medicinal:* (1)

Calomel.....gr. 1-10
Bicarbonate Soda.....gr. 1
Sugar of Milk.....gr. 2

Give every half hour until the stools change in character.

Then follow with (2):

Paregoric or Deodorized Tincture of Opium.....q. s.
Subnitrate Bismuth.....2½ drams
Simple Syrup.....
Pepsin Cordial (P., D. & Co.).....1 oz. of each

Give one teaspoonful, after feeding, until bowels are checked, then every 4 or 5 hours. The opiate to be regulated by child's age.

Food.—Condensed milk of proper consistency; Mellin's Food, tablespoonful to ½ pint; Pepsin Cordial, teaspoonful to ½ pint; prepare fresh; give warm in quantity according to age, and continue until stools are normal as to character and frequency. In very young children the Mellin's Food may be omitted.

Acute Indigestion—Cholera Infantum.—Large, watery stools; fever; vomiting; thirst and rapid prostration.

Stop all food of whatever character; reduce the temperature, if high, by sponging with cool water.

Medicinal: (1) If vomiting is present give the calomel powders until relief is obtained. Small pieces of ice should be given if the child is old enough. It allays thirst and helps to quiet the stomach. If the child is seen at the beginning it is best to use the calomel powders under any circumstances. If vomiting is not present and there is much prostration, they had best be omitted.

(2) The bismuth mixture above mentioned should be given every half hour, the opiate being omitted if there is much fever. The ingredients should be varied in quantity, according to the age of the child and the urgency of the symptoms, and the interval lengthened as indicated.

Food:—White of one egg (not beaten), granulated sugar to sweeten water, six ounces. Ducro's Elixir, liquid peptonoids

or Elixir Alimens (P., D. & Co.) ½ ounce, strain. Give one ounce at a time every hour at first and increase as required, continue until the fever abates and the acute symptoms have subsided. Then commence with the condensed milk mixture—every other feeding at first.

This egg mixture has saved many children at my hands. When the egg is beaten it does not dissolve so readily, and many children object to the froth. The straining is necessary to remove flocculi of egg that cause vomiting in some children. In selecting an "alimentary elixir," the main ingredients of which are said to be brandy and predigested essence of beef (?), the one having the most agreeable flavor should be chosen, everything else being equal. Children soon tire of this mixture, unless it is properly made, and refuse to take it, or the stomach will reject it. Generally it will not be required alone for more than 24 or 48 hours. The question arises: Why condensed milk? I make it a rule never to recommend cow's milk for an artificially fed child, unless:

(*a*) I know the milk to be from a healthy cow.

(*b*) The nurse is both intelligent and reliable.

(*c*) There are facilities for having the milk at least twice in the 24 hours and of keeping it at a low temperature.

(*d*) Another objection is that the pepsin cordial coagulates warm cow's milk and small children can not eat the curd. Condensed milk is used, because:

(*a*) It is sterile and of uniform composition.

(*b*) Anyone can prepare it for use.

(*c*) Easily kept and freshly prepared for each feeding.

(*d*) Is not coagulated by pepsin cordial, except very slowly, unless too much is added.

It must be understood that in those children taking breast milk, no other *milk* is substituted. For older children a very agreeable and easily assimilated food is made by adding a teaspoonful of pepsin cordial to a half pint of sweetened cow's milk, to which a teaspoonful of Mellin's Food has been added. The pepsin cordial is a preparation made by Park, Davis & Co. I do not know that it is either a patented or a secret formula. It is the most palatable form of pepsin that I know of (which is no small advantage), and one of the most efficient. While I am not given to the praise of any manufacturer's wares, still I

have had such excellent results from the use of this article—not only in the indigestions of children, but in the alimentary diseases of adults—that I can not pass it by without specially favorable comment.

Where the larger bowel is involved, as indicated by the presence of mucus, blood and membranous shreds in the stools and of colic and straining, I have found most effective as a local measure, flushing of the large bowel. Half a gallon of warm water to which silver nitrate has been added, in the strength of one-half grain to the ounce, should be used. This is done through a soft rubber catheter, passed high up, and not oftener than once every two or three days. I have tried to indicate as briefly as possible the treatment that has given me the best results. Elaborate methods are either neglected or improperly carried out, except in rare instances. A simple, easily understood plan, not requiring too much time and attention, will be observed by the poor and the uneducated, among whom a large proportion of these maladies occur.

ACUTE RHEUMATISM IN CHILDHOOD WITH REPORT OF TWO CASES.

By E. D. FENNER, M. D., Lecturer on Diseases of Children, Medical Department Tulane University, First Assistant Surgeon Charity Hospital, New Orleans.

Case I.—Ladd House, white child; was admitted to the hospital on March 21, 1900, at 8 P. M., with temperature 99 deg. F., pulse, 100. He exhibited marked choreic movements, and talked very incoherently. He was unable to stand or walk. He was given a hot bath and put to bed, but spent a very restless night.

Second day, March 22.—Patient is much quieter than when admitted, but still exhibits movements of a typical chorea. The muscles of the tongue are involved and speech is very much impaired. Some swelling of the wrists, with pain and tenderness in these as well as in other joints, but with no local heat or redness, indicate the rheumatic origin of the disorder. The forehead and hairy scalp are covered with many fibrous subcutaneous nodules, many of them as large as a hazelnut. The rapid pulse, 120, is accounted for by a marked endocarditis and pericarditis.

March 23 to 30.—Boy continues to be very restless; sleeps little at night; pulse ranges from 100 to 140. Temperature has varied between 99 and 100 deg., being always higher at night. Urine has varied in quantity from 40 to 50 ounces daily. Nothing abnormal has been found in it. He has been more quiet at night and appears to sleep some.

March 31.—Mind seems to be clearer.

April 2.—Up to this time he has been taking a mixture of sodium salicylate, sodium bicarbonate and lithia citrate, and has been nourished exclusively on milk, ℥vi every two hours. To-day salicylate stopped and lithia gr. v, with potassium bicarbonate gr. v, substituted every four hours.

April 3.—The nodules on forehead are getting smaller; some of them are going away. New ones are coming out on chest and on flexor tendons of wrists.

April 4 to April 9.—Numerous nodules are out on wrists, and a number on chest and on hamstring tendons. Head continues to show an extraordinary number of nodules. Slight joint pains and loud endocardial and pericardial murmurs continue. Pulse is rapid, heart dilated, and its action tumultuous. Chorea is getting better. Same treatment.

April 9.—Citrate lithia gr. v, iodide of potash gr. v, every four hours. In addition to milk, the diet has been somewhat increased. Teaspoonful mist. ferri et ammonii acetatis three times a day.

April 16.—Urine normal, blood, 52 per cent., hemoglobin, 2.610,000 red corpuscles, 82,000 white corpuscles per *c. m.*

April 18.—Nodules nearly all gone; only a few left on back of head. Has had some cough and has required bromide and chloral occasionally to secure rest.

Throughout the active period of the endocarditis and pericarditis, the ice bag was used more or less constantly over the heart. It seemed to act as a sedative and to relieve pain and cardiac distress.

The clinic ward notes were discontinued on April 26, as all active symptoms had ceased. But the boy was much emaciated and very weak from his long illness and was not strong enough to get out of bed till the middle of June. He has no traces left of the chorea, the nodules, or the rheumatic pains, but his heart is badly crippled. Dilatation, a loud mitral murmur, and evidences of pericardial adhesions, testify to the severity of the

rheumatic attack, in spite of the mildness of the arthritic manifestations.

A tendency to involvement of the kidneys was shown on March 23, two days after his admission, when the urine was found to contain hyaline, finely granular, and granular casts, with sp. gr. 1023. On March 29, however, only hyaline casts were found, with specific gravity 1024, and on April 16, the specific gravity was 1010, and no casts were present, the reaction being alkaline.

CASE 2.—James McFadden, white child, was admitted at 2 P. M., March 26, 1900, with a history of having been sick four weeks with fever and pains in his limbs. On admission his temperature was 101.2 deg., resp. 40, pulse 124. He coughed a great deal, but examination of the lungs revealed nothing. The heart was involved in a well marked endocarditis. Joint tenderness and pain, mild; no swelling or heat. He was put upon a milk diet, given a calomel and soda purge, and lithia and salicylate of soda ordered every 4 hours.

March 30.—Highest temperature has been 100½ deg.

March 31.—Evening. Temperature at 4 o'clock, 102 deg. Complains of pain in limbs. Pulse, 120; respiration, 38.

April 1.—3 A. M. Temp., 102.8 deg.; pulse, 144; resp., 40.

April 2.—4 A. M. Temp., 102.8 deg.; pulse, 144; resp., 42. Same pain over heart. Pericardial friction very sharp at 1 P. M. Pain in left side. Evening temperature, 103 deg.; pulse, 138; resp., 48. Ice cap to head and over heart. Mustard poultice over upper lobe left lung.

April 3.—Ice cap to head and heart all day. Temperature did not exceed 102.4 deg. Pleuritic friction explains pain in lung.

April 4.—Since poultices do not relieve pain over lung, ice bag substituted with good effect on pain and temperature, which fell to 100 deg. by 12 o'clock that night.

From April 4 to 7 the ice bag was kept continuously on heart and applied intermittently to head and left lung. The patient got along very well and temperature did not exceed 100 deg. but once, the evening of April 6.

April 7.—Has complained of pain in right side, slept little during the night. In the afternoon a pleuritic friction sound was plain over base of right lung. A mustard poultice applied for ten minutes and then replaced by ice bag.

April 8 and 9.—Ice bags continuously to both sides of chest. Has had to be sponged twice for high temperature. Some consolidation in right lung. Pulse has been weak and sometimes irregular.

April 10.—Small fly blister to base of left lung. Sponged for temperature once.

April 11.—Ice bags have been kept on continuously. No change in pericardial friction sound, which is still marked. Respirations have been very rapid and labored.

April 15.—Patient has been getting along better. Temperature has been gradually getting lower till to-day it is not higher than 99½ deg. Pericardial friction diminished and softer. Pleuritic friction nearly gone. Ice caps to-day removed.

From this time the history is of one gradual victory over the prostration and weakness into which the boy had fallen. Not until the beginning of June was he able to get out of bed, and when he was discharged in the latter part of June, it was with a badly crippled heart.

The importance of rheumatism in childhood can not be too much emphasized. It presents variations from the same disease in the adult which are important to remember. The acute inflammatory rheumatism, rheumatic fever, is not frequent in the young. Comparatively seldom do we see the hot, red, swollen joints, exquisitely sensitive to touch or motion; an arthritis dominating by its severity the whole clinical picture. On the contrary, the joint symptoms are apt to be mild in the child; often they are hardly noticed by either the parents or the patient. But if endocarditis and pericarditis are often due to rheumatism in the adult, they are still more common complications in the young. Even the mildest attack of rheumatism in them is liable to be attended by serious involvement of the heart, and in every rheumatic manifestation in children, inflammation of the outer or inner lining of the heart should be feared and watched for. The histories of the two cases presented illustrate this point. In neither of these boys were the joints very seriously involved. Neither movement nor pressure gave any such pain as might have been expected in an adult. At no time were any of the joints either hot or reddened. Yet surely more severe manifestations of the power of the rheumatic poison are seldom seen.

There is a curious relation between rheumatism, endocarditis and chorea in the young. They are nearly always associated. Sometimes as in one of my cases we see them all together, but this is not usual. Sometimes and more frequently they succeed one another. Now we see an attack of chorea following an exhibition of joint pains; again we see a rheumatic attack following one of chorea. And nearly always careful examination will reveal a heart movement at some time in the course of either chorea or rheumatism. The extraordinary predilection of juvenile rheumatism for the fibrous and serous structures is exhibited by the involvement of pleuræ and lung in one of my cases and by the subcutaneous fibrous nodules seen in the other. This complicating lung involvement is not uncommon in childhood, and the subcutaneous nodules are seldom seen in older patients. Rarely are these nodules as numerous as in the present case. Generally they are only fifteen to twenty in number and found along the extensor tendons; less commonly over the flexors. They vary in size and subside as the other symptoms abate. In this case they were found not only on both wrists in large numbers, but on the hamstrings, the chest and all over the head in astonishing number. They lie just beneath the skin and are not apt to be sensitive to pressure. A very common manifestation of latent rheumatism is tonsillitis and this is true in childhood as in adult life.

As a subsidiary deduction the history of these two cases emphasizes what my experience has shown me in other cases, namely, that the ice bag is a safe and reliable agent in pericarditis, pleurisy and pneumonia. It relieves pain, reduces temperature and shortens the attack. And it can be borne almost continuously without ill results. When we reflect upon the frequency of heart complications in childhood, we realize the danger of lightly considering even the mildest attack of rheumatism in the young. The heart weakened by a rheumatic endocarditis may easily give way under any strain and leave the patient with a crippled circulation for the rest of his life. And the moral to be drawn from these facts is that every complaint of joint pain in the young should be looked into carefully, the heart examined in every case of rheumatism, and every precaution taken to protect it from overstrain. Absolute rest in bed is the best safeguard to the heart and should be insisted on as far as possible.

Purpura is a complication of rheumatism rarely seen except in childhood. In them it is not uncommon and seems to be an expression of the blood dyscrasia, which always occurs. In both rheumatism and chorea an examination will always show a marked anemia, with decrease in both red corpuscles and hemoglobin.

Clinical Lectures.

Specially Reported for the JOURNAL from the Philadelphia Clinics.

I.

PNEUMONIA AFTER SURGICAL INJURY.*

By DR. ARTHUR V. MEIGS.

This woman is forty-five years old; she was admitted to the hospital December 27; she had fallen down stairs and sustained, it was supposed, a fracture of the lower end of the fibula, but after a while it was decided that there was no fracture present, only a sprain. On examination the urine was found to contain albumin, the specific gravity was 1012; she had been drinking previously, so they gave her strychnin and whisky. The temperature was up to 102 and 103 deg.; the tongue was coated and dry; her respiration increased in frequency, and she became worse, so that she was finally transferred to us from the surgical ward where she had been. Here the first examination was rather unsatisfactory. It was thought she had some inflammation of the lungs and some cold, a very unsatisfactory thing for a physician to say, but it is all you can say sometimes.

She was transferred to us on January 1. She had a temperature as high as 104 deg. She had some fever on admission, but after a few days the temperature fell and has been subnormal, and now she is a great deal better. She has been here about three weeks, and she was here in the ward from the first to the ninth before we got evidence that was perfectly satisfactory as to the existence of some pulmonary disease. At the

*From a Clinical Lecture Delivered at Pennsylvania Hospital.

present time there is very little to be discovered from percussion posteriorly. There is a difference in the tones, but I don't think I could tell just what it was unless I had known the conditions existing before. On the ninth it was noted that there was marked dullness on percussion over the lower portion of the right lung. There was absence of the natural breath sound, and negative signs are often as important as positive ones. The vesicular expansion was absent and there was an adventitious sound described as a "crumbling." Fremitus was equal on the two sides. At the left base the breath sounds were fairly good, but there was the "crumbling," Most people would have said this was pleurisy. When such an eminent man as Scoda said that it was impossible to tell the difference between the fine crepitant râle of pneumonia and a friction rub, I don't think I always can. Probably there was some pleurisy, there, because there almost always is when there is pulmonary trouble.

It is a curious condition. The woman was admitted to the sugical ward in apparent health and in a day or two she had this fever. It was thought she had been drinking and she probably had; also there was albumin in the urine. She was more sick than was warranted by the disease of her lungs, and I felt sure there was some disease of the kidneys; and I am sure now that there was beside the condition of her lungs.

The lung condition is interesting because it does not tally with the description you find in books. It is a lower grade—a catarrhal form of pneumonia. There is dullness and absence of normal vesicular sound. There is no fine crepitant râle and no bronchial breathing such as you would expect to find in bronchopneumonia. It comes on from drinking here.

At one time I was quite doubtful as to the prognosis. She was delirious and quite seriously ill. She was put on the tincture of digitalis, 5 minims 4 times a day, and 2½ grains carbonate of ammonia with 20 minims of paregoric every 2 hours. This was equivalent to one-twelfth grain of opium every 2 hours. Those were the principal things given. When she was violently delirious I ordered them to give her 15 drops of laudanum, and if this did no good to wait an hour and give her 10 drops more. I frequently find that this does good. I had never in my life seen it do any harm and it frequently does good.

The patient gets a quiet sleep and rest is better the next day. I am no believer in large doses of opium. If small doses do no good there is no use in giving it.

II.

CASE OF PERIPHERAL NEURITIS — METHODS OF EXAMINATION.*

By Dr. CHAS. WELLS.

From what I have learned about this patient in a few minutes she will furnish good material for the opening up of the subject. She is a woman thirty-two years old, married, has several children. There is nothing special in the past history before this attack. She was rather stout when quite young. There is nothing in the history that would give us an insight into the cause of the trouble. She was well until last summer. In August she was taken with pain in the right side extending around the body. She began to tremble and feel bad all over. Then she had pains in the right thigh, very soon extending down the limb and then to the other side, and involving then both arms. She says it was very severe. She lost power and only in the last week or two has regained sufficient power to stand.

This woman has disordered sensation, disordered motion and doubtless some condition of the reflexes, so will furnish me with some of the elementary points in regard to examination. The first procedure is to examine the sensory side. Persons may have pain without any hyperesthesia, a very common thing. When you catch the foot and press it backward, if there were any inflamation it would give a great deal of pain. There is no pain here. If you are examining for neuritic pain, if you take the calf and press it the skin may prove sensitive. Next you should seek out the nerve trunks, searching the popliteal space and along the crural nerve. We see there is not much sensitiveness here. Examination does not show any marked tenderness, though she does say that formerly this pressure would have caused pain. It is the same in the hands and arms. Her tactile sense and sense of location are good. We had a patient at the Neurological Society last night where the sense of location was almost gone though the tactile sense was good. I saw a patient

* From a Clinical Lecture, delivered at the Woman's Hospital.

yesterday where the sense of temperature was disturbed; everything seemed hot to her. This woman has seemingly all the forms of sensation preserved. Muscular sensibility has not been tested. You should test for the stereognostic sense, or the sense by which you can tell the three dimensions of space by manipulation. Curiously it is sometimes independent of cutaneous sensibility. We have a woman at the Philadelphia Hospital who has insensibility on one side, and she can manipulate objects and tell what they are. On the other hand some will retain cutaneous sensibility and can not tell an object on manipulation. The muscular sense and the stereognostic sense are not the same, though the muscular is a part of the stereognostic sense. That it does exist is shown by the anatomic parts.

When you examine for motion or disordered motion you examine for loss or impairment, for exaggeration, as in spasm, local or general, and for co-ordination. So far as I can see there is no loss of co-ordination. You should not only determine in a general way that a limb is paralyzed, but examine for the particular muscles or muscle groups involved and try to isolate the loss of power. She might be unable to walk and yet have large retention of power above the knee, as is the case in some infantile palsies. These things are so simple that I almost hesitate to present them, yet I so often see physicians going about an examination in a wrong way. Every doctor, every student should learn to recognize instantly whether muscles are affected, and to refer the loss of power to the individual muscles or group, then to the nerve, then to the part of the spinal cord, to the internal capsule, and then to the centres in the brain.

She seems to have a total loss of all movement below the knee. She is paralyzed below and paretic above the knee, but retains a great deal of power above. Then the reflexes should be investigated. In a healthy individual we should have response of some kind from irritating the soles of the feet. There are one or two responses from the sole that may enable you to tell very much what is the nature of the disease. If when you irritate the sole at the metatarso-phalangeal articulations the toes bend up instead of forward and downward as in the "gooseneck reflex," there is something abnormal. Here there are none of the reflexes. What about trophic and vaso-motor

disorders? There is evidently atrophy of the thenar and hypothenar eminences, and I think the muscles have largely disappeared from the forearm. She said she never lost control of the bladder or bowels.

While she is before us we had better come to some conclusion as to diagnosis, which is not so easy, as it would seem from the evident symptoms taken in connection with her history some difficulty arises. It is multiple neuritis, or some form of neuritis, or a generalized myelitis. On the whole it would seem to me to be a very general peripheral neuritis. It is not true that only the nerve trunks are involved. It is not proper to say this is a peripheral neuritis or a polio-myelitis, because we have to modify the statement. It is some disease involving the cells of the ventral horns of the cords and involving the peripheral neuron system. It has left the woman with a chance of life and recovery. She should have rest, as she has been having, and constructive remedies. Not too much massage and electricity. We can not tell how much will be restored to her.

Charity Hospital Notes.

Specially reported for the JOURNAL.

SPLENECTOMY.

CASE OF DR. H. S. COCRAM,

PROFESSOR ON CLINICAL GYNECOLOGY IN THE NEW ORLEANS POLYCLINIC, NEW ORLEANS.

MRS. B., white, was admitted to the hospital June 29, giving the following history: Age 40, married at 21, has given birth to 17 children; was 20 years of age when first child was delivered; last child was born nine months ago; no miscarriages; menses appeared at age of 12, and have always been regular. She first noticed enlargement in the left hypochondriac region about seven years ago, which increased only slowly and occasioned little inconvenience or suffering until about four weeks ago, since which time the tumor has rapidly increased in size and given much pain and distress, loss of strength being especially noticeable; her weight has also diminished ten pounds; bowels were

open and regular, although jaundice was a noticeable symptom. Patient appeared weak and depressed. Examination revealed a tumor extending from a point high up in left hypchondrium transversly to right iliac fossa; on palpation a sharp edge to this tumor was recognized. On July 2, Dr. Cocram, assisted by Dr. Clark, operated. Under chloroform anesthesia an incision about eight inches in length was made slightly to the left of median line; the enlarged spleen was readily encountered, adherent to every viscus with which it had come in contact and recognized as the affected organ. The adhesions were broken up after some difficulty, and the spleen was lifted out and its pedicle ligated and cut. It was now noted that the organ had been twisted upon its pedicle. Two ligatures were subsequently placed upon each the splenic artery and vein to make double assurance against hemorrhage. Abdominal cavity was sponged, washed out with hot saline solution and closed. On account of cardiac weakness the chloroform was never pushed to profound anesthesia. Infusion of normal salt solution was instituted during the operation and continued for some time after its completion; about one-half gallon was introduced. Patient was profoundly shocked, but under stimulation and the effects of the infusion she was removed from the operating room, at the end of two hours, in fairly good condition. The spleen was found very friable and greatly engorged with venous blood, and there was every evidence that the sudden rapid enlargement and accompanying symptoms occurring during the four weeks prior to operation were due to the organ being twisted upon its pedicle and consequent obstruction to venous circulation. The removed spleen weighed seven pounds. The ultimate cause of primary enlargement was not determined. No examination of the blood was made.

After removal to ward, patient received a hot saline enema, which produced diuresis; during the first twenty-four hours she received beef tea and brandy by the rectum, since which time she has been upon liquid diet, administered by the mouth. Free stimulation with strychnin and digitalis has been resorted to. All the emunctory organs have functioned normally. Six days after operation patient was in good condition with a normal pulse and temperature.

Result: On July 31 patient was discharged from the hospital entirely recovered.

SUPRA-VAGINAL HYSTERECTOMY FOR INTRA-MURAL FIBROIDS.

Case of Dr. C. JEFF. MILLER, Assistant to the Chair of Obstetrics and Gynecology in the New Orleans Polyclinic, New Orleans.

Alice H., a well nourished negro woman, aged 30 years, married, was first seen July 8, 1900. She stated that her menstrual flow appeared when she was 13 years of age, and remained regular and normal in every respect until June, 1899, since which time the flow has been protracted and profuse in quantity, gradually increasing until just prior to admission to the hospital the loss amounted to considerable hemorrhage and lasted two weeks. She has never conceived. Simultaneously with the above mentioned derangment in the menstrual flux there was pelvic discomfort, backache, vesical tenesmus. Physical examination revealed the presence of a mass about the size of a clenched fist apparently involving the upper portion of the uterus. A diagnosis of intra-mural, multinodular and subserous fibroids of the uterus was made and operation of hysterectomy elected. The patient being prepared, under chloroform anesthesia, the entire uterus was removed through the supra-vaginal route. The right ovary was found to contain a blood cyst and appeared otherwise diseased, and was accordingly removed. The left ovary and tube, being normal, were left intact. The wound was closed with silk worm-gut sutures—no drain being used.

The tumors were about the size of a large hen's egg. They occupied the uterine cornua on both sides. The cavity of the uterus had been very much encroached upon, and could contain no more than 10 or 15 drops of fluid. Patient has done well since operation. Nine days having elapsed, the pulse and temperature are normal. The wound never suppurated.

HYPERTROPHIC CIRRHOSIS OF THE LIVER.

Case of Dr. GEO. S. BEL.

The patient is a negro male, aged 17 years. He was admitted July 25. His present trouble dates two months back, when he first noticed an enlargement in his right hypochondrium, which has steadily increased in size until now it encroaches upon his

abdominal viscera to such an extent as to cause considerable inconvenience and interfere with the descent of the diaphragm to some extent. His stools have been of a yellowish color, the urine highly colored and loaded with bile pigments. He vomits occasionally; the vomited matter being of a decidedly greenish color. You will readily notice his jaundiced condition. At irregular intervals he sustains attacks of colicky pains in the region of the gall bladder which are immediately followed by more marked jaundice and intensification of the other mentioned symptoms. On palpation we can readily detect the indurated, enlarged liver, imparting something of a granular sensation to the touch. By passing the finger underneath the lower border of the hypertrophied organ and catching it between the fingers thus inserted and the thumb we can more readily distinguish its thickness and consistence. It can readily be outlined, and appears more than twice as large as normal. There is very little, if any, ascites. The patient's gums bleed readily; the same condition is present in the intestines. In proceeding to arrive at a diagnosis in this case, we can eliminate cancer; for were this the nature of the affection we would have an enlarged, nodulated, very painful liver—painful not only on manipulation, but during intervals of quiet the patient would experience sharp, lancinating, shooting pains. The pains present in this case are not of this character. There would also be the cachexia, and evidence of inflammation in the liver tissue; cancer would not be looked for at this patient's age in life—while hypertrophic cirrhosis is more commonly observed in the young. Another disease likely to be confused with hypertrophic cirrhosis is the amyloid liver; in this condition we have an enlarged, smooth organ; there are present none of the subjective symptoms elicited in this case—and then a syphilitic history, together with manifestations of tertiary syphilis, become apparent. In the case of hydatids the liver is enlarged, irregular in outline, soft, and generally perfectly painless. A diagnosis of hypertrophic cirrhosis of the liver is therefore quite well established. Just what causes this destruction of the parenchymatous and hyperplasia of the connective tissue of the liver is at present unknown. The treatment of this affection is at best palliative. I am convinced that the liver should be given physiologic rest, and not stimulated as

some advocate We are giving him iodide of potash and treating symptoms as they arise. The prognosis is unfavorable. It is impossible to predict how long the patient will live. Cases have been known to linger ten years, others succumb more quickly—in two or three years.

Miscellany.

Treatment of Tetanus by Injection of Brain Emulsion.—Schramm (*Centralblatt für Chirurgie*, Nov. 1, 1900) had brought to him a girl, nine years old, who, five days after a wound, developed symptoms of tetanus, which became violent in three more days. An emulsion of guinea-pig's brain was made in a sterile salt solution. This was filtered, and ten grams of the filtration was injected subcutaneously. The treatment was followed by almost immediate improvement. It was repeated once four days later.

Hic Jacet (Quaint Epitaphs):

"Here lies the body of Susan Lowder
Who burst while drinking a sedlet powder
Called from this world to the heavenly rest
She should have waited till it effervesced."

"Died when young and full of promise,
Of whooping cough—our Thomas."

"Sacred to the memory of three twins."

"Here lies Jane Smith, wife of Thomas Smith, Marble Cutter. This monument was erected by her husband as a tribute to her memory and a specimen of his work. Monuments of the same style are two hundred and fifty dollars."

—*Ex.*

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE WHITE PLAGUE.

The agitation all over the world upon the question of tuberculosis must bear some fruit. A glance at the mortality record of any urban community will show a record of almost appalling fatality. As yet the world has contented itself with the search for curative measures; the element of diagnostic importance being for the time relegated as secondary. Prophylaxis here and there has been touched upon, but only too sparingly.

Communities are slow in accepting educational measures which are made current only through the secular press. They read and perhaps estimate the dangers, but as soon forget them. Sanitary measures have gradually been advanced, but not nearly so fast as to prevent the growing frequency of tuberculosis with its concomitant ravages. In Chicago for May there were 250 deaths from consumption among a total mortality of 2088, or a percentage of about 12; New Orleans, in July, had a mortality of 63 in a total of 561, or nearly 9 per cent. In both instances, as with other large cities, this disease occupies the first place among the diseases with fatal results. And this has been so as well for years gone by. The habits of the people, in their community life, intermarriage, public conveyances and in many other ways, are conducive to the spread of a disease so currently prevalent and so readily acquired.

An intelligent crusade is within the development of events of the near future and people must be made to respect health laws, if they can not see why they should be followed voluntarily.

Congresses on tuberculosis have been in vogue for a decade; this year the question in all phases will be discussed in Paris, and much is hoped for in the deliberations which will soon be published to the world.

While the panic grows quickly at the thought of foreign invasion by unfamiliar disease, the ravages of the white plague go on day by day, without even the thought from most of us that this disease has a sum total of victims perhaps greater each year than any other known disease

When some tangible scheme of public protection is devised, the legislators of all our United States should be swift in seeing its provisions materialize.

TESLA'S ELECTRIC UNIT.

Not content with having solved in large degree the question of wireless transmission of the physical electric vibration so as to make it a practicable utility, Tesla now proposes the application of the same law in the study of the electric momentum, we might call it, of the human individual.

If we can follow his argument, the field of speculative experimentation in our laboratories is to be very much broadened. Questions of psychologic study, hitherto explained upon the simple theory of vibration, never too clearly, may now find a basis of theory as tangible as other more materialistic problems in electric science are getting to be.

Psychometry, the study of sensation, suggestion and psychophysiology may find easier solutions, if Tesla's theory of electric units in the individual obtains.

We have come a long ways in the study of vital phenomena, and every generation has seen a greater advance, and while today may find the spark of origin of crystallized existence, we are yet not ready to solve the elementary essential of the *vis a tergo*, although—

"A Hair perhaps divides the False and True."

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

A Modification of the Murphy Button for Gastroenterostomy to Prevent its Falling Back into the Stomach.—Heinrich Hildebrand, in the *Centrbl. fur Chir.*, June 30, 1990, describes a modification of the Murphy button which mechanically prevents its falling into the stomach, and thus assures its safe passage into the intestine.

This modification consists in nothing more than in the making of the button-halves of unequal sizes. The half looking towards the stomach is the smaller, so that it readily passes through the opening, the button being so clamped that this opening corresponds exactly to the size of the half within the stomach. Since, then, the button can not pass into the stomach and can pass into the bowel, naturally it passes on down and can not lie indefinitely in the stomach, requiring ultimately a laparotomy for its removal. Another incentive to its downward passing lies in the fact that the smaller or stomach half is also lighter, which of course gives it a downward tendency, obeying the law of gravitation. Whether in practice the button shall show the advantages claimed for it by its inventor time alone may reveal. Would not the typical Murphy button applied to the posterior wall, as has been now numbers of time done, do away better with this danger of having the button fall into the stomach? However, the anterior operation being easier, should it be shown that this modified button really answers the purpose well, then it will gain wider field of usefulness. The button has been used by Kümmel in the Eppendorf hospital many times with good results.

Hypospadias Treated by Beck's Method of Operating.—Ferdinand Valentine, in the *Medical Record* of July 28, 1900,

reports a case successfully operated on by the method of Carl Beck. Since this operative procedure is so far superior to any heretofore recommended for the same variety of cases, namely, the balanic forms, it will, we feel sure, be interesting and instructive to our readers to describe the technic of the operation as laid out in the articles of Valentine now quoted and that of Beck originally published in the *New York Medical Journal* for January 29, 1898.

The method is of course only applicable to the balanic forms, or to those in which the urethral orifice is situated very near the normal line of the corona glandis; in other words, the urethra, after having been dissected up from its bed, must be capable of extension up to the site of the normal meatus.

The Beck operation embraced the following steps:

1. A transverse incision is made across the lower surface of the glans embracing the hypospadiac opening.

2. Having freed the integument from around this opening, the skin is pulled down by grasping it with a tenaculum just behind the hypospadiac opening.

This exposes the dorsal aspect of the urethra.

3. The urethra is now caught up with a pair of forceps and being gently lifted is gradually dissected up from its bed until it is quite free and can easily be drawn up until it can be made to occupy the site of the normal meatus. This must be done without permitting the urethra to act as a bowstring giving rise to a curving of the penis.

4. The groove in the glans penis is now made raw, the urethra is laid in it and tacked by a few sutures so as to hold it securely in place.

5. The skin is now drawn together about the urethra in such a way as the integumental incision is united in a longitudinal line, thus materially adding to the support of the canal.

Valentine describes the operation as performed by him as follows:

"An incision was carried from the centre of the abnormal urethral opening, through the skin, to the posterior third of the pendulous portion. At the upper end of this incision another was made through the skin, encircling the lower third of the neck of the penis, immediately below the coronary sulcus. The skin-flaps so obtained were dissected back to expose the lower

third of the penis. Then the urethra, together with its corpus spongiosum, was dissected from its bed between the corpora cavernosa penis. A narrow straight bistoury was then thrust through the glans from below upward and well behind the sulcus which normally would have been the fossa, making a new meatus about a quarter of an inch behind the topmost angle of this sulcus. The point of emergence of the knife was enlarged by turning it to the right and to the left, making an incision at each side. After the knife was withdrawn, a long, narrow forceps was passed from above through the channel and the urethra grasped. Owing to the longitudinal extensibility of the urethra, first described by Beck, it was rather easy to draw the freed end of the urethra through the channel perforating the glans and to attach its opening by means of four sutures to the new meatus."

It will be seen that the technic of the two operators differs in some, though unimportant, particulars. Thus, Beck freshens the glandular sulcus by paring away the mucous lining, whilst Valentine preserves the floor of this sulcus, simply perforating the glans beneath it and pulling the urethra through. As Beck assisted Valentine in the latter's operation, we may safely conclude that this procedure had his endorsement, and it would seem to us to have the advantages of being somewhat more expeditious than paring, and of also actually strengthening the dorsal wall of the canal, which, in Beck's technic, is only reinforced by the integument.

We have ourselves within the last few days done the operation on a seven months' old child with great satisfaction. We were much struck by the simplicity of the procedure and by the sound surgical principles upon which it is based. There is no loss of continuity in the urethra, so that there can be no urinary escape except at the very end where the periurethral tissues are thoroughly protected by the manner of suturing. We have found it advantageous to continue the transverse incision as a circular cut around the urethral opening, leaving a flange of tissue which facilitates the subsequent suturing. The secret of success lies in the mobilizing of the urethra, so that it may be carried well and easily forward to the end of the glans and there fixed, without incurving the penis. The procedure is, therefore, applicable to all cases, no matter what the age, where this urethral extension can be done, and to no others. Fortunately, these

balanic forms are by far the most numerous. Finally, there seems little reason to doubt that Beck deserves the credit of this operation and it should properly be called by his name.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans, La.

The Indications for the Employment of Cesarean Section, Symphyseotomy and Craniotomy in Contracted Pelvis.—During the past two years a host of authors have discussed this question in every phase, but it has been only a short time since practical results could be examined and the proper merits of the different procedures appreciated.

Dr. J. Whitridge Williams contributes to the *Maryland Medical Journal* a thorough and comprehensive article on the subject which contains the latest summary of the work done in the largest clinics of the world, The articles which have appeared upon the Cesarean section and symphyseotomy have placed the former operation on much firmer ground than it previously occupied. During the past two years articles have appeared from the clinics of Leopold Zweifel, Gustave Braun, Chrobak, Olshausen and Schanta, which gave a total of 278 conservative Cesarian sections, with a gross mortality of 7.5 per cent., and a corrected mortality of 4.8 per cent; and 87 Porro Cesarean sections with a gross mortality of 10.3 per cent., and a corrected mortality of 2.5 per cent. This corrected mortality consists of the cases which presented no infection at the time of operation. Very favorable reports have come from France during the past year, Bar reporting ten cases with one death, and Charles, of Liege, ten consecutive cases without a death. Reynolds, of Boston, has also reported fourteen consecutive Cesarean sections with no death.

It is apparent, says Williams, that the mortality of Cesarean section, when performed upon uninfected patients by competent operators, is less than 5 per cent and should not be greater than

the mortality following operations for uncomplicated ovarian cystomata. On the other hand when performed upon infected cases the results are extremely disastrous, reaching as high as 23.5 per cent as collected by Doktor of Budapest.

Turning to symphyseotomy we find that Pinard, whom it must be remembered is the father of symphyseotomy in France, lately reported 100 consecutive symphyseotomies, with twelve deaths. He also justly claims that a considerable number were profoundly infected when operated upon, that their death should not be attributed to the operation and shows a corrected mortality of 5 per cent.

Abel, of Zweifel's clinic, in a report of fifty Cesarean sections and twenty-five symphyseotomies remarks that there is very little if any difference in the mortality of the operations. He claimed, however, that patients recovered far more rapidly from Cesarean section, being able to walk on an average within 3 weeks, but not until 13 weeks after symphyseotomy. Another point, their ability to work is to be considered. They were able to do hard work 4 or 5 weeks after section, but not until four and one-half months after symphyseotomy. The ability to walk after the latter operation was directly proportionate to the degree of pelvic contraction. This shows that the sacro-iliac synchondroses are considerably damaged.

Summing up the advantanges of Cesarean section as compared with symphyseotomy we find the material mortality the same or less, the fetal mortality practically nil, a more satisfactory operation from a surgical standpoint, as a clearer view of the field is permitted and no second operation by the vagina is necessary, which is frequently accompanied by marked injuries to the soft parts. It enables one to complete the operation no matter how great the disproportion between the size of child and pelvis, whereas in symphyseotomy an incorrect estimate may necessitate craniotomy even after cutting the pelvis. There is no comparison between the after treatment of the two operations. Everything is in favor of section.

The indications for Cesarean section are no longer limited as formerly. With increased proficiency in pelvimetry and surgical technic a section can be done where perforation was once the accepted method. The old absolute indication should disappear, and instead of being placed at a conjugata vera of 2 to 2.2 inches, should be extended to 2.6 inches provided the child

is alive. If the pelvis is somewhat larger the indications are not so clear, and it can be stated that in a conjugata vera of 2.8 inches the course of labor will depend upon the size of the child, the consistency of its head and the character of the labor. In such cases it is advisable to allow the patient to go into labor and see first what nature can do before determining upon the operation. If the head shows no sign of descending no attempt at delivery should be made but perform Cesarean section, provided the child is alive and the mother in good condition. When the pelvis is larger, *e. g.* 3.2 inches, a tentative attempt of forceps may be made before deciding upon section. If the head does not follow, the forceps should be removed and section performed.

If such a mode of procedure is adopted version will disappear from the treatment of contracted pelvis, because if any obstacle is encountered after its performance the child will die before symphyseotomy can be done.

The form of operation preferred by Williams is the typical conservative Cesarean section. Supra vaginal amputation should be reserved for cases infected at the time of operation or when the possibility of infection is great.

Should the patient be sterilized at the time of operation? Sterilization can be effected in several ways, but the ovaries should not be removed. Excision of the tubes and uterine cornua by wedge shaped incisions is the most rational procedure. The responsibility of sterilizing the patient should rest with the patient and husband, if intelligent. If the patient is ignorant and unable to understand the condition, the surgeon must assume the responsibility. Williams would feel justified in rendering a woman sterile after her first pregnancy only in idiots unless her condition demanded supra vaginal amputation.

The marked improvement in mortality following section and symphyseotomy has made the operation of craniotomy much less secure in its position as an obstetric operation.

In cases where the child is dead it is always indicated in pelvic contraction. This operation, so generally considered harmless, has been shown by Pinard to have had a mortality of 11.5 per cent. in eighty-one destructive operations. Williams' experience is that in uninfected women it is almost devoid of danger if properly done, but he does not believe it should be done if

the patient is uninfected, suitable surroundings are possible and a competent operator procurable. Craniotomy still has a place among obstetric operations, but its performance should be restricted to the greatest possible extent and only performed when the dangers to the mother from other operative measures are so great as to make them practically unjustifiable.

The indications for the induction of premature labor have also been greatly disturbed by surgical technic. It was extensively employed in the past. Every one agrees that the maternal mortality is almost insignificant if done properly. Pinard's death rate is one per cent. It should be performed six or eight weeks before expected date of confinement, but then the child is imperfectly developed, and its chances for life are not particularly bright. Pinard and Charles report the fetal mortality at 33 to 36 per cent., which seems a very poor showing. It is only a difference in degree between performing an operation which saves only one-third and doing craniotomy which kills all. If solely in the interest of the mother it appears to be an excellent operation, but why not do an abortion at a much earlier period and save her the weary months of pregnancy. The operation has a distinct field in multiparous women with normal pelves who have repeatedly given birth to large children who died during labor, children of 11 and 12 pounds or more. In such cases it would give more satisfactory results than Cesarean section.

In conclusion the author repeats the warning that his remarks only apply to those who feel competent to do major surgical operations. Neither Cesarean section nor symphyseotomy are operations which should be attempted by one who has no surgical experience. Craniotomy is considered as yet the safer operation for the average practitioner.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Edema of the Lungs.—Often, in the course of nephritis, pulmonary congestion occurs, confining itself to limited areas for weeks, and even months, manifesting itself with the usual

small moist râles, easily detected by the medical attendant, and yet the latter wrongly overlooks and, still more, ignores this, while the common cerebral congestion is always thought of and looked for as the only formidable complication. This, however, is a grave error. Pulmonary edema is to be feared more than uremic coma, since the latter is, so to speak, expected and preparations are being made to meet it, the medical attendant having informed the family of and even at times cautioned the patient himself against the dangerous occurrence. Edema of the lungs, on the contrary, comes so suddenly, and without warning sets upon the patient at the time he apparently enjoys good health. In fact, it is not so, for there may have been found in the urine some time prior traces of albumin. A strict diet caused it to disappear, and both patient and physician are tranquilized.

Suddenly, during night, the patient is taken with a peculiar malaise, respiratory distress, abundant expectoration of a pinkish froth, livid face, purplish lips, cold extremities. Often the patient dies, then and there to the great amazement of his family and physician, before any efficient help is given to him. Such occurrences teach us a lesson; caution and preparations to meet the emergency might be lifesaving. Energetic interference is in order.

First. Bleeding; from 300 to 500 *c.cm.* of blood should be drawn.

Second. Dry cupping back and chest.

Third. Spice poultices over and around lower extremities.

Fourth. Hypodermics of ether in large doses, a sure and prompt measure; of caffein; of camphorated oil 10 per 100, a decidedly safe and efficient remedy.

Fifth. Drastic purgatives, viz.: compound tincture of jalap (40 *c.cm.*); infusion of Epsom salts and senna, etc.

Sixth. Strict milk diet; draughts of water with bicarbonate of sodium or with sugar of milk, freely given. Attention is called before closing to the common and dangerous routine of administering opiates to relieve this distressing condition. In edema of the lungs morphin is to be prohibited.—Dr. J. A. Le Sage, in *L'Union Medicale du Canada*, June, 1900.

Clinical Hints.—The following are notes gathered without going into specific details from the report of a medical case in

Professor Rendu's wards (Hôpital Necker, Paris). As usual Rendu's instructive observations, remarks and comments in scrutinizing obscure cases, in others words, clearing up and solving a difficult diagnosis are worth retaining carefully.

1. To inquire into the cause of a case of coma, chiefly in hospital practice, is always a difficult and ticklish matter, since, for want of direct interrogation and inquiry from the family information on exisiting conditions and previous history (anamnesis) is nil.

2. Cerebral hemorrhage is not always manifested by hemiplegia. To cause hemiplegia the hemorrhage must be located in either one of the following territories, viz.: thalamus opticus, corpus striatum, anterior columns or psychomotor zone. When occurring in any other region, as in the white substance of either frontal or an occipital lobe it causes a stroke of apoplexy not followed by paralysis.

3. Hemorrhage in cerebellum causes also apoplexy and vomiting, coma is surprisingly rapid and profound; for several hours temperature is low, then it rises as in all cases where the bulb and protuberance are affected.

4. In uremia subnormal temperature is the rule, while in meningitis and encephalic hemorrhages, the temperature rises.

Uremia might present the appearance of apoplexy, but it is attended with contracture. In uremia the tongue is dry and there is complete suspension of the excretion of urine.

5. Aside from the *classic type* of cerebro-spinal fever (by the way look for Kernig's sign, viz: when the thigh is placed at right angle with the trunk, the leg can be only partially flexed), there is a *typhoid form* (by the way look for pupillary signs), rose-colored spots, Widal's test, and there is an *apoplectic form*. In this, look for rhinitis, otitis and bronchitis, since the infection by streptococci and pneumonococci is known from autopsies to have proceeded direct from there to the cerebro-spinal apparatus. Consequently, in presence of a case of apoplexy and coma, think also of cerebro-spinal fever.

6. Vomiting always occurs in grave lesions of the encephalon.

7. Suppuration in the meninges may exist without hyperthermia and without any fever at all, until the few hours preceding death.

8. Many infections affecting serous membranes cause no rise

of the temperature, as for instance, in the course of puerperal peritonitis when the abdomen is full of pus, the thermometer may not register more than 37.5 deg. C., or 99.5 deg. F. In the course of purulent pleurisy fever is found to be absent. The same absence of fever is seen in purulent meningitis.

9. Spinal symptoms may be absent or little marked in cerebro-spinal fever cases.

10. Delirium which usually stamps cases of pneumonia in alcoholic patients should not mislead us and bar the search for signs of actual meningitis.

11. La Grippe, in other words, pneumonococcic broncho-pneumonia, like septic bronchitis, leads to meningitis.

12. The apoplectic type of cerebro-spinal fever is not always fatal; but, as a rule, prognosis in cerebro-spinal is grave. Epidemics may be of a mild type.

13. Hydrotherapy is highly beneficial in cerebro-spinal fever; but beware of cold baths. Use warm baths only. If the diagnosis between typhoid fever and cerebro-spinal fever can not be made with certainty, in the doubt it is safe to avoid cold baths. —*Méningite cérébro-spinale anormale. Clinique Médicale du Prof. H. Rendu. Journal de Médicine Interne, 15 Juin*, 1900.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Epicarin in Dermatology.—(*Klin. therapeut, Wochenschr.*, 1900, p. 586.) According to Prof. Pfeiffenberger, epicarin will occupy an important position in the treatment of scabies and prurigo. In eczema the author has seen no beneficial result—rather the contrary. In all children treated the following ointment was applied:

℞	Epicarin	7.0
	Cret. alb.	2.0
	Vaselin alb	30.0
	Lanolin	15.0
	Adipis	45.0

—*The Therapist.*

ELIXIR TERPIN HYDRATE AND DIONIN.—

℞ Terpin hydrate ..... 16 grn.
Dionin ..... 2 grn.
Alcohol ..... 5 fl. dr.
Glycerin ..... 10 fl. dr.
Ext. vanilla ..... 1 fl. dr.

Each teaspoonful (1 fl. d.) represents one grn. of terpin hydrate and $\frac{1}{8}$ grn. of dionin.

—*Merck's Archives.*

FORMULA FOR THE USE OF TANNALBIN.—

℞ Tannalbin ..... 1 dr.
Spirit cinnamon ..... 2 min.
Aromatic powder ..... 10 grn.
Sugar ..... 10 grn.

Make 10 powders. One every two or three hours.

(In summer diarrhea of children.)

℞ Tannalbin ..... 2 dr.
Brandy ..... 2 fl. dr.
Syrup ..... 4 fl. dr.

Distilled water to make 2 fl. oz. Teaspoonful 4 to 6 times daily.

(In summer diarrhea of nurslings.)

℞ Tannalbin ..... 1 dr.
Dover's powder ..... 8 grn.
Aromatic powder ..... 10 grn.
Sugar ..... 6 grn.

Divide into 12 powders. One every 2 hours for 2 or 3 doses, then every 4 to 6 hours for child about 1 year; double this dose for 2-year-old children.

(In summer complaint.)

℞ Tannalbin ..... 3 drams.
Morphin sulphate ..... 1½ grains.
Salol ..... 1 dram.
Camphor ..... 12 grains.
Ichthalbin ..... 2 drams.

Divide into 12 powders, one every 1 or 2 hours. (In Asiatic cholera.)

℞ Tannalbin ..... 4 drams.
Oil cassia ..... 2 drops.
Morphin sulphate ..... 2 grains.
Sugar ..... 15 grains.

Dispense in 12 powders, one every 4 hours. (In cholera morbus of adults.)

℞ Tannalbin ..... 1 ounce.
Ichthalbin ..... 1 ounce.
Peppermint oil sugar ..... 20 grains.

Divide into 15 powders, one 3 times daily before meals. (In chronic dysentery of adults.)

℞ Tannalbin ..... 2 drams.
Resorcin resublimed ..... 15 grains.
Glycerin ..... 1 fl. ounce.
Cinnamon water to make ..... 4 fl. ounces.

Dessert spoonful every 3 to 4 hours for child 2 to 3 years of age, shake well. (In acute enteritis in children.)

℞ Tannalbin ..... 3 drams.
Ichthalbin ..... 1½ drams.
Powder opium ..... 10 grains.
Oil cassia ..... 2 drops.

Divide into 24 powders, two every 4 hours. (In phthisic diarrhea of adults.)

℞ Tannalbin ..... 4 drams.
Ichthalbin ..... 2 dr.
Resorcin resublined ..... 40 grn.

Dispense as 16 powders, one 3 times daily.

(In tuberculous diarrhea of adults.)

℞ Tannalbin ..... 6 dr.
Bismuth subgallate ..... 2 dr.
Salol ..... 2 dr.

Dispense as 48 powders, two or three thrice daily.

(In phthisic diarrhea of adults.)

℞ Tannalbin ..... 3 dr.
Ichthalbin ..... 1½ dr.
Cinnamon oil sugar ..... 20 grn.
Salol ..... 1 dr.

Make 12 powders, one every 3 or 4 hours.

(In later stages of tuberculous diarrhea in adults.)

℞ Tannalbin ..... 2 dr.
Syr. wild cherry ..... 12 fl. dr.
Wintergreen water ..... 4 fl. dr

Dispense in 3 oz. bottle. Teaspoonful for child and dessertspoonful for adult every 1 to 4 hours, according to severity of case. Shake well before using.

(In summer diarrhea where tannalbin powder can not be taken dry.)

℞ Tannalbin ..... 2 dr.
Ichthalbin ..... 1 dr.
Oil cinnamon ..... 1 drop.
Syr. acacia ..... 2 fl. dr.
Peppermint water ..... 4 fl. dr.

Two teaspoonfuls for adults, one-half to one teaspoonful for children, according to age, every 1 to 4 hours, according to severity of case. Shake well before using.

(In severe cases of chronic diarrhea.)

℞ Tannalbin ..... 3 dr.
Bismuth subnitrate ..... 2 dr.
Dionin ..... 3 grn.

Dispense as 12 powders, one every 3 hours.

In typhoid diarrhea of adults).

℞ Tannalbin ..... 2 dr.
Salol ..... 12 grn.
Peppermint oil sugar ..... 12 grn.

Dispense as 12 powders in parchment papers. For child 1 year 1 powder at first every 2 hours, then once in 4 to 6 hours; for 2-year-old children, 2 powders constitute the dose.

(In summer complaint.)

℞ Tannalbin ..... 2 dr.
Camphor ..... 10 grn.
Aromatic powder ..... 20 grn.
Sugar ..... 20 grn.

Divide into 24 equal parts, and dispense in parchment papers. One every 2 to 4 hours for child of 1 year, 2 powders per dose in children 2 to 3 years old. (In cholera infantum.)

℞ Tannalbin ..... 1½ grn.
Calomel ..... 1 grn.
Dover's powder ..... 15 grn.

Dispense as 20 powders. One every 2 hours for first three doses, then every 4 to 6 hours for child of one year; 2 powders per dose in children 3 years old. (In acute infectious diarrhea, with pain.)

—*Merck's Archives.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King, New Orleans.

Peri-tonsillar Abscess Associated with Diphtheria.—These two diseases of the throat, though frequent enough as individual processes, are rarely found associated. Thomas Hubbard, of Toledo, reports two cases of the kind in which there was every evidence of virulent infection, with both the Klebs-Loeffler bacillus and pyogenic cocci. In one case, a man 30 years of age, a peri-tonsillar abscess formed and was incised; the next day both tonsils and the pharynx were covered with diphtheritic membrane. Pus continued to escape from the tonsil and the membrane spread into the larynx and trachea and a hurried tracheotomy was performed. The patient died later of the diphtheritic infection and edema of the lungs. Three other members of the family developed diphtheria and recovered under anti-toxin treatment.

The second case was one of well marked peri-tonsillitis associated with membrane formation in the pharynx. A large quantity of pus was evacuated from the tonsil and the patient recovered after treatment with the anti-toxin. Several members

of the same family were suffering with sore throat at the same time and a sister of the patient died with every symptom of diphtheria.

In conclusion the author states: "This series of cases of mixed infection suggests that the virulence of the different bacteria, together with the age and natural resisting power of the patient, determines which type, false or true diphtheria or peritonsillitis, shall predominate."—*N. Y. Medical Journal.*

Anesthesia by Bromide of Ethyl in the Rose Position.—Malherbe, of Paris, recommends the use of this anesthetic very strongly for short operations on the nose and throat, and insists that it should be administered with the patient in the Rose position. He finds that this facilitates operative procedures and lessens the danger by preventing a flow of blood into the larynx. In more than three thousand cases in which the anesthetic had been used he never saw a fatality, but advises care in its administration.—*Revue Hebdomadaire de Laryngologie, etc., 30 Juin*, 1900.

Closure of a Cleft Palate by Lingual Transplantation.—Carl Beck, of New York, gives a preliminary report, in the *New York Medical Journal* of June 30, of a case of extensive cleft palate, in which, after failure of other methods, he implanted a flap cut from the tongue. After nine days the base of the flap was severed, and one week later the flap was united with the opposite margin of the cleft. The result of this novel procedure was excellent.

Purulent Rhinitis of Childhood as a Cause of Atrophic Rhinitis.—Richmond McKinney, of Memphis, publishes two cases in support of Bosworth's theory that atrophic rhinitis is caused by purulent rhinitis of childhood. The cases in question were two brothers who gave clear histories of purulent rhinitis. In the older boy was found upon examination marked atrophy of the nasal turbinates with ozena and anosmia. In the younger the atrophid process was advancing in one fossa, while the other was still affected with purulent rhinitis. The evidence is good in favor of the Bosworth theory.—*New York Medical Journal*, June 30, 1900.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

Sympathetic Ophthalmia Caused by Glioma of the Retina.—The author's patient, aged 5 years, had become blind in the left eye two years prior to any symptoms of inflammation. A year later the eye became inflamed and painful, and enucleation was performed with a view of preserving its fellow, that now presented marked symptoms of photophobia. Adherent to the the periostum of the left orbit was found a round, yellowish, elastic tumor of the size of a chestnut. The enucleated eye was affected with a glioma involving the optic nerve of the same nature as the orbital tumor. Cases of sympathetic ophthalmia due to intra-ocular tumors are not yet very numerous.

—Adolph Alt, in *Recuil D'Ophthalmologie.*

Operative Treatment of High Myopia.—The work of DeSpeyr (*Revue Med. Suisse romande*) concerns a subject that has been considerably discussed for some time; the author himself has had occasion to operate on a certain number of cases for two years past.

He calls attention first and foremost to the fact that myopias of ten diopters and over are not at all rare, and have a tendency to become more and more frequent. The discomforts and even the dangers of a myopia of fifteen to twenty diopters are numerous. Such high myopes can almost be considered as blind as soon as they are deprived of their glasses, and there are many who can not accept the strong concave lenses that improve their distant vision. Visual acuity, with the best correcting glass, is usually found reduced several degrees below normal.

High myopia is nearly always progressive and its progress frequently brings about the gravest complications, such as choroiditis of the macular region and detachment of the retina. This last accident frequently causes sudden blindness in the myope and it is so much more to be feared owing to the hopelessness of its treatment. It has been noticed that individuals

with myopia ranging from 11 to 12 diopters, affected with senile cataracts, could, after extraction of the cataracts, use their eyes, without convex glasses, at least for distant vision, the refraction having become emmetropic through a reduction of 11 to 12 diopters.

This fact engaged Mooren, the celebrated oculist of Dusseldorf, to bring about a cataract in myopes in order to transform, by the extraction of the cataract, the myopia into an emmetropia. Mooren failed in his first trial and his idea was not taken up until much later, in 1891, by the Austrian oculist Fukala, so that the operation for high myopia is now currently credited to Fukala; soon the results obtained led other oculists to follow this procedure, and this operation is now actually practised in all countries.

The method generally employed consists in a discission of the crystalline lens with a needle. The point of the instrument penetrates the cornea and opens the anterior capsule of the lens, the entrance to it of the aqueous humor is followed in a few hours by swelling of the lens and the formation of a soft cataract, total and homogeneous. As soon as the cataract becomes complete, that is to say from 5 to 8 days, one may proceed with its extraction. One frequently obtains a dark pupil immediately after the first operation, but it usually fills up with cortical substance and becomes opaque within a few days.

This debris is general absorbed slowly by the aqueous humor. The majority of operators have found it necessary, a month or two later, to discise on account of secondary cataract.

It has happened by chance, that the author has not been forced to this additional intervention in but one case, and he attributes this to the use of iodide of potash, which he invariably prescribes after the operation and which appears beyond doubt to promote the absorption of the cortical masses. The use of the iodide in these cases has been recommended by Ascher, of Frankfort-on-the-Main. Dr. DeSpeyr has used general anesthesia only once and that in a boy 8½ years old, who was the youngest of his patients. The average age of his 13 operated cases was 17⅓ years. He operated nine times on the right and four times on the left eye. The degree of the myopia varied among two of his patients from 6 to 24 diopters. Visual acuity was on an average one-third of normal; in 4 cases it was only

one-fifth and in 1 case it was one-half. The average duration of treatment was 30 days.

Dr. DeSpeyr has determined that the visual acuity *per se*, without considering the difference of refraction, had been notably ameliorated in the majority of cases; it remained unchanged in 3 cases, but at least the myopia had been cured. In one case the visual acuity rose from one-third to 1. Two operated cases have not yet reached a definite visual acuity owing to secondary cataracts of a very tenacious character.

In one case Dr. DeSpeyr noticed a temporary erythropsia; for instance, for several weeks certain bright objects such as snow appeared red to the patient, this phenomenon being met with occasionally after operation for senile cataract. In conclusion, this method may be considered as marking a decided progress, for it secures vision without glasses to operated cases. It is well, however, for one to choose his patients and to follow the following rules: Operate if possible before twenty-five years of age, for after this the complete extraction of the lens becomes more difficult; choose cases of 15 diopters and over unless we are dealing with a myopia manifestly progressive. Choroiditis is not a contra-indication. Only extensive leucomata corneae can constitute a sufficient reason for non-interference.

As a rule, it will suffice to operate upon one eye only; the fellow should be operated upon only through the patient's formal desire, and this at least six months after the first operation.—*Recuil D'Ophthalmologie.*

Miscellaneous.

Psychologic Problems Relating to Confessions of Innocent Persons.—Dr. Thomas Jay Hudson, at a meeting of the New York Medico-Legal Society, May 16, 1900, read an interesting paper on this subject from which we have selected the following:

"It is well known to every student of forensic medicine that, from time to time in the history of criminology, cases have been

reported of criminal confessions made by persons who have subsequently been proven to be entirely innocent. * *

"When innocent children and reputable women confess to crimes, the penalty for which is the most horrible form of death, we may know that they *believe* what they say. Knowing this, we also know that it is a mental state or condition which we have to diagnose. In attempting this diagnosis, it must be remembered that the psychologic principles which apply to one case are equally applicable to all.

"The victims of witchcraft prosecutions evidently believed that their confessions were veridic. This is unquestionably true. We must, therefore, find a psychologic principle under which a perfectly innocent person may be made to believe that he is guilty of a capital crime; and, so believing, be made to confess the crime, knowing that immediate death is the inevitable result of the confession. To that end we must find: First, a universal psychologic law, applicable to all persons alike, conditions being equal, under which an innocent person can be compelled to believe that he has committed a capital crime. Secondly, we must find another universal law under which a condition of mind may be induced in which death loses its terrors. * * *

"I need not dwell upon the supreme potency of suggestion, for every student of psychic phenomena is aware that a subject may be made to believe himself to be a dog or a devil, a demon or an angel, the spirit of a deceased person or a living personality other than his own; and that he will carry every suggestion to its logic conclusion so far as it is physically possible. It follows that he may be made to believe that he is guilty of crime. All that is necessary is that the suggestion be made with strength, vigor and persistency. Reason is dethroned; experience counts for nothing; the evidence of the senses is impeached; the centre of control over the dual mental organism is displaced, and as long as this subjective state continues, or as often as it is renewed, the subject is dominated by the central idea embraced in the suggestion.

"We have now found the law for which we were in search, namely, the law now under which an innocent person can be compelled to believe that he he is guilty of a capital crime.

"Every student of psychic phenomena is aware of the extreme facility with which a sensitive subject may be thrown into the

subjective condition. Thus, Abbe Faria was accustomed to hypnotize his subjects by gazing upon them for a few moments and then suddenly shouting '*dormez*'—sleep—in authoritative and strident tone of voice. Charcot performed the same feat by flashing a Drummond light into the eyes of his patients; and others have induced profound hypnosis by suddenly sounding a Chinese gong. In short, it is well known to all hypnotists that sudden fright is a potent agency for the induction of the subjective condition.

"What is more to our present purpose, however, is the fact that a never failing emotional agency for the induction of the subjective condition is the dread or fear of imminent and inevitable personal calamity. It may be set down as axiomatic that Nature is ever kind to the victim of the inevitable. And this is true whether it is inevitable death or an inevitable surgical operation. Where the two conditions of imminence and inevitability are present the rule is inevitable. It is Nature's compensation for her prodigality of life, and the universality of death made necessary by the process of organic evolution. The apparent cruelty of the law that all must die is mitigated in the only way possible, namely, by universal immunity from pain during the process of dissolution. And this immunity is made possible by the spontaneous induction of the subjective condition upon the near approach of the king of terrors. Even the soldier in battle experiences this immunity—not only from pain when struck by a bullet, but from all fear of death while the battle lasts. And, if mortally wounded, he treads the inevitable path without fear and without regret.

"It will now be seen that, in the admission by courts of justice of confessions of guilt by persons charged with capital crimes, there is constant and imminent danger of being led into that greatest of all judicial misfortunes—the capital punishment of an innocent person. If that humane and merciful maxim of the law is to prevail, that it is better that ten guilty men should escape than that one innocent person should be punished, a rule of evidence must be adopted, forbidding the consideration, under any circumstances, of confessions by persons charged with capital crimes. And the first step in that direction should be the abolition of what is known, in the parlance of criminal detectives, as the 'sweating' system; that system under

which a detective is turned loose upon a person charged with murder, and allowed to browbeat him into a confession before he has a chance to employ counsel. It matters nothing that the rule prevails excluding the confession if the party is not cautioned that all he may say will be used against him on the trial; for the psychologic condition necessary to secure a 'voluntary' confession can just as well be induced by a shrewd detective after such a warning as before. Every one who is familiar with the sytem alluded to will bear me out when I say that the facilities are just as available to-day for inducing the psychologic conditions necessary for securing a confession of guilt from an innocent person, as they were under the inquisitorial system of days of medieval superstition.

"These remarks, as before intimated, apply exclusively to confessions of capital crimes; for it is not certain that the psychologic conditions which we have been considering could be induced in cases not involving the life of the accused. That is to say, it is not certain that the subjective state could be induced in criminal cases by anything less than the fear of death or of physical torture.

"As in all other cases where the line of observation is new, much must remain in doubt as to the limit of application of the law of suggestion to criminal confessions. But I think we are even now warranted in assuming that the following fundamental principles are reasonably well established:

1. The dread of impending death will cause certain persons to enter, spontaneously, the subjective condition.

2. In the subjective condition the subject is constantly amenable to control by the power of suggestion.

3. A strong suggestion, vigorously enforced by a dominant personality upon a person in the subjective condition, will cause the latter to believe in its absolute verity, and to act upon it in all essentials as though it were true, even though the suggestion be contrary to fact, reason, experience and the evidences of the senses.

4. Finally, the proposition that works back to the foregoing and invests it with perennial importance to courts of criminal justice, is that, assuming the constancy of Nature, whatever power, faculty or limitation belongs to any one individual, must exist, potentially, in every member of the human family."

Louisiana State Medical Society Notes.

[All personal and other items of interest are requested.]

THE JOURNAL has called attention to the fact that it is now the official organ of the Louisiana State Medical Society.

Regular space will be allotted to matters referring to the Society or its members.

Arrangements have been completed by which all members of the Society in good standing may receive the JOURNAL free of cost. The payment in advance of current dues to the Society will assure the delivery of the JOURNAL regularly for the year.

THE CHAIRMEN of Sections are notified that at an early date in the fall the Committee of Arrangements will solicit titles of subjects for general discusion at the coming meeting in April next.

As was done last year, all notices referring to the program will be issued by this committee.

NOTICE.—The undersigned committee appointed by Dr. F. W. Parham, president of the Louisiana State Medical Society, for the purpose of gathering information and offering suggestions on the following questions, solicits your kind co-operation:

(1). What substances or preparations, if any, recognized by the United States Pharmacopeia of 1896, should be left out of the new pharmacopeia!

(2). What new substances or preparations, if any, should be admitted into the new United States Pharmacopeia?

Specific statements rather than general criticisms, are desired.

A reply to the above questions will aid the cause of progressive medicine, and will be highly appreciated by the committee.

(Signed). Committee { E. M. DUPAQUIER, M. D.
H. P. JONES, M. D.
J. A. STORCK, M. D., *Chairman*,
124 Baronne St.

Medical News Items.

International Congress of Deontology and Professional Medicine, Paris, 1900.—The following is a resumé of some of the papers read:

On the Usefulness of an Order of Physicians, considered: 1st. In their relations among themselves. 2d. In their relations with society. 3d. In their relations with justice—Dr. A. Couvreur (of Paris) believes in the possibility and necessity of a disciplinary order as projected within the past few years by Jamin (of Paris) and Lasalle (of Lormont). It would include all respectable physicians irrespective of medical doctrine, religion or political opinions; but this new institution would have full power to suppress charlatanism and correct misbehavior among practitioners. The order, looking into the future and fearing the great increase in the medical ranks will render more difficult the obtaining of a diploma and through a contribution from members and endowments will establish a fund for the poor and unfortunate confreres.

In its relation with society its voice would be felt in the parliament of the nation with the force that association alone can confer, and its advice on questions of general hygiene and prophylaxis would be acclaimed. In its relations to justice it would be no less valuable in relieving physicians from the numerous dead beats who prey upon them and protecting them in the courts when attacked for malpractice.

On the Evils to Public Health by the Practices of Magnetizers, sorcerers, hypnotizers, mind readers and pseudo-physicians—Professor Ottolenghi (of Sienne) cites recent instances and mentions the fight waged by the medical world, against charlatans. He suggests that more severe punishments be meted to those guilty of illicit practice of medicine and of the abuse of public credulity and still graver punishments to those who repeat the offense; that efficient police measures be adopted for the prohibition of the commerce of fortune telling, etc.; in reserving to medical men only the privilege of practicing hypnotism. In brief he proposes a wise prophylaxis consisting in making known

to the masses the doctrines concerning occult psychic phenomena, in the more ample application of psycho-therapy in order to strengthen the character while diminishing the number of victims to human credulity.

Hospital Abuse in Paris.—Mr. Paul Thiery (of Paris), having been charged with the duty, reports a large number of instances of abuse both of hospitalization and free clinic in Paris, particularly at the Hospital Dubois, by people able to pay. These crowd the wards and clinic rooms to the evident detriment of the physicians of the city and of the really poor and needy. As a remedy to this state of things, Mr. Thiery is of the opinion that no one paying or able to pay should be admitted into the hospital until all indigents have been fully taken care of. To insure this much desired condition he suggests the following steps: 1. A perfect understanding between the city physicians and the hospitals. 2. The legislature to enact laws regulating hospital work. 3. The hospital boards to multiply the difficulties for the person of means to obtain admission as a patient. The following means to be adopted: A notice to be posted inside and outside of the hospital specifying that admission and treatment are reserved to the indigent, and the conditions of admission. Secondly, a system of investigation be inaugurated to establish the financial status of persons presenting themselves for treatment. Thirdly, a written agreement signed by the patient to reimburse the hospital when his declarations have been found fraudulent, and in case of repetition of the offense the patient to be punished by fine or imprisonment.

The Thirteenth International Medical Congress met in Paris August 2 to 9, 1900. The attendance was uusually large and the meeting notable. We have been able to review some of the sections giving the discussions of more important papers read:

Section on Dermatology and Sypilography.—Dr. Unna, of Hamburg, discussing *the parasitic origin of eczema*, summarizes as follows: The uncertainty regarding the pathogeny of eczema is due to the absence of a proper classification of the cocci generally; these pathogenic elements should be studied exactly and their laboratory technic defined.

To definitely determine the parasite in eczema it is necessary to prove that the histo-bacteriologic lesions produced by inoculation are identic with the histo-bacteriologic lesions of eczema. Among the numerous micro-organisms found in eczema there are several which inoculated will produce eczema. The work at first, then, ought to be to report the different forms of eczema as related to and affected by different micro-organisms.

Dr. Unna concluding dogmatically with the statement that eczema is a contagious disease, and in certain circumstances, epidemic.

Dr. Jadassohn, of Berne, in detail traced the several micro-organisms incident to eruptions of eczema and reviews his observations as showing that in eczema there are types where one can not discover micro-organisms as either determining or influencing the pathogenic element. In these we must admit as etiologic factors, predisposition, both local and general and chemic and mechanic irritation.

Jadassohn confesses to the belief that in various degrees the parasitic element may exaggerate a condition of the skin already determined as an inflammation.

Dr. Galloway, of London, believes that the question resolves itself into the study of the bacteriology of the lesions of the skin and the weighing of the evidence so obtained. In concluding his remarks, Dr. Galloway acknowledges the presence of micro-organisms in eczema, which probably determines the local infectivity and chronicity of this disease. The production of eczema, however, is due to other causes: Predisposition, seborrheic state, imperfect metabolism.

Drs. Brocq and Veillon, of Paris, agrued that the term eczema should be defined, and then we may be able to study the pathogeny so far as microbes were related to the disease so limited.

An attack was made upon Unna's seborrheic eczema, and the prurigo of Hebra, pityriasis rosea, poriasis, etc., were discussed in their relations to the proposed definition of eczema, and this question was dwelt upon. In conclusion Drs. B. and V. agreed that:

(*a*) In the present state of our knowledge regarding a specific micro-organism in the cause of eczema, it remains to prove that such exists.

(*b*) The primary lesions of eczema, the vesicles, do not con-

tain a micro-organism detectable by any process now known in bacteriology.

(*c*) The different micro-organisms (especially the staphylococcus) found abundantly in weeping and crusting eczema, constitute a *secondary* infection, which does certainly provoke most of the complications in eczema, but which can not be held as a primary cause.

The second question discussed at this section was *the tuberculides*.

Dr. Boeck, of Christiana, after an analysis of his and other opinions grouped these as follows:

(1) Acnitis; (2) Erythema indurata (Bazin); (3) Angiomatous tuberculide of Leredde; (4) Dermatitis ex-foliativa generalis subacuta malignans; (5) Pityriasis rubra (Hebra.)

He concluded by saying that the lines of distinction between cutaneous tuberculosis and the tuberculides of the skin are not very marked; they are transition types. There is none the less reason, theoretic and practical, to place the tuberculide in a group apart.

Dr. Roberto Campana, of Rome, recognized a closer resemblance and confesses the impossibility in a clinic distinction between a tuberculide of toxin and one of bacillary origin.

Dr. Darier, of Paris, argued a resemblance in common among all tuberculides which he groups together, leaving the distinctions to the pathologic differences.

The third question discussed in this section was on *La pelade*, including the type of skin disease generally called "alopecia areata." The origin of this disease has long been in dispute. Dr. Lassar, of Berlin, reviewed the current opinions regarding alopecia areata, and acknowledged that treatment was as empyric as the etiologic factor was indefinite.

Dr. Pavlof, of St. Petersburg, had discovered in his clinic that the cultures of 8 of 10 cases had proved positive in that he had found the staphylo-coccus pyogenes aureus and albus, but no tricophyton. He expressed the opinion that alopecia areata to him was not a contagious disease.

Norman Walker, of Edinburg, inclined to deny the identity of alopecia areata and ringworm, and confessed to having failed to find such relationship in his own investigations. He had observed instances of apparent contagion which were not clear in his mind.

In all of his cultures he had obtained Saboraud's "Porcelain" growth. After 14 to 28 days all of his cultures developed a deep brownish, black color, apparently due to the growth of another organism, which he was not ready to put forward as a claimant for the honor of being the cause of alopecia areata. Dr. Saboraud, of Paris, concludes his observations as follows: The name "pelade" should apply alone to alopecia areata—as at present other conditions are very likely confused with the disease. Of pelade he distinguishes two forms:

1. *La pelade ophiasique* (of Celsus): More frequent in infants. Begins on the occiput; extends circumferentially; slow in growth, cured by puberty; hereditary; contagion rare, if it exists.

2. *La pelade seborrheique* (of Bateman): Occurs in middle-aged adult life. An initial patch, followed by after a time by secondary patches; all patches orbicular; seborrheic infection; microbacillary; contagion rare but possible, and definite.

Dr. S. considers the subject one of the most obscure in dermatology and one which, in the absence of the clinic experiment, would continue obscure.

Under the division devoted to Syphilography, several papers were read on syphilis and associated infections. A digest of these showed that beyond the statement that syphilis might be modified by concomitant disease, nothing of interest was deduced. A more important question was that of the *descendants of hereditary syphilitics*, to which Tarnowsky, of St. Petersburg, Finger, of Vienna, and Jullien, of Paris, were contributors in the discussion.

Section on General Surgery.—The subjects for general discussion and a resumé by those announced to open these have appeared and we briefly abstract the following for our readers:

The Surgery of the Pancreas was the first question which was discussed by Ceccherelli, of Parma; Thayo Robson, of Leeds; Boeckel, of Strasburg, and others. Ceccherelli summarizes the questions in point and argues that surgical operation is guided by the importance in the function of the pancreas: Fatty excretions, sugar in the urine, bronzed skin, icterus and pain are the indicative symptoms.

The removal of the pancreas is practicable and does not jeopardize the life of the patient; in syphilitic and tuberculous processes the operation is contra-indicated.

The tumors occurring in the pancreas and demanding operation are hematomata and hydatids, or cysts; pancreatic calculi may be operated usefully.

Necrosis of the pancreas, suppurative or gangrenous pancreatitis demand operation; the last two named, however, when the acute symptoms are in abeyance.

After reviewing the whole field of indications, Ceccherilli candidly advises that in extirpation of the pancreas, care should be taken to make all ligation preceding incision; and he discourages the use of the cautery, urging the danger of wholesale injury from the irradiated heat produced.

Robson is more discursive, reviewing the symptomatic side of the question, and especially lays stress on the palliative surgery. Pancreatic cysts, cancer, pancreatitis, chronic interstitial pancreatitis, each finds a place in the review.

Boeckel reviewed the statistics of pancreatic surgery as an argument for interference: Suppurative and gangrenous pancreatitis furnish the record of 11 cures and 9 deaths in 20 cases; hemorrhagic pancreatitis, 5 cures and 18 deaths in 23 cases. Solid tumors of the pancreas have given 8 cures, 4 permanent, and 3 deaths in 11 cases. In 144 cases of cysts of the pancreas operated upon the following were the results:

Operation once; 99 cases, 92 cures, 7 deaths.

Operation twice; 16 cases, 16 cures.

Total extirpation; 25 cases, 21 cures, 4 deaths.

Four cases without details furnished; 3 cures and 1 death.

Cholecystenterostomy furnished 15 cases, 7 deaths, 8 cures.

Cholecysto-gastrostomy (4 cases with amelioration), pancreatico-enterostomy (1 case, 1 failure), and gastro-enterostomy (2 cases, 1 rapid death, 1 survived four months), ought to be cited for the sake of record.

The subject of *radiography in the study of fractures and luxations* was brought up and discussed by Maunoury, of Chartres, and v. Bergmann, of Berlin. Much stress was laid on the diagnostic importance of employing the X-ray. Particular reference was made to the determination of single or multiple fragments and the relations of these.

Among other subjects discussed were the treatment of infected wounds; intestinal anastomosis, etc.

Absentees.— Among the physicians away in July and August were Drs. F. Formento, Otto Lerch, O. Joachim, W. Scheppegrell, C. N. Chavigny, H. S. Cocram, Paul Reiss, Felix Larue, J. N. Roussel, J. M. Batchelor, and Chas. Chassaignac.

The Louisiana Legislature has passed an act prohibiting the sale of tobacco, cigarettes, etc., to minors, and the law is now in effect.

Personal.—Dr. H. E. Ménage has returned from an eighteen months' stay in the Philippines. He is on furlough after active army service near and in Manila.

Dr. C. P. Wertenbaker has been placed in charge of the New Orleans Station of the Marine Hospital Service. The doctor is considered one of the best men in the service with whicn he has been connected a number of years. He was stationed for some time in Galveston, and comes originally from Virginia.

Dr. Warren S. Bickham has been again distinguished with an appointment as assistant to Professor Hartley at the College of Physicians and Surgeons in New York.

Dr. G. F. Powell, of McLendon, Tex., is now on the staff of the North Texas Hospital for the Insane, at Terrell, Tex.

Dr. E. A. Blount, for some time assistant to the chair of Dermatology in the New Orleans Polyclinic, has decided to remove to his old home at Nacogdoches, Tex., where he will engage in general practice.

The American Association of Obstetricians and Gynecologists will hold its thirteenth annual meeting in the Assembly room of the Galt House, Louisville, Ky., Tuesday, Wednesday and Thursday, September 18, 19, and 20, 1900, under the presidency of Dr. Rufus Bartlett Hall, of Cincinnati, O. A number of interesting papers are announced. A cordial invitation is extended to the medical profession to attend the several sessions of the association.

The Roentgen Society of the United States, will meet in New York City, December 13 and 14, 1900, at the Academy of Medicine. Papers have been promised by eminent men abroad and here, and a very successful scientific meeting is assured.

All those wishing to become members or to read a paper before the Society may communicate with Secretary Dr. J. Rudis Jicinsky, Cedar Rapids, Ia.

State Board of Dentistry.—Governor Heard has made the following appointments to this board: Drs. John E. Woodward, R. L. Zenenka, J. Sidney Couret, C. B. Johnson and Geo. A. Colomb.

The New Orleans Polyclinic will open Monday, November 12, 1900.

The New Orleans College of Dentistry will open October 9, 1900.

The Mississippi Medical Record, now located at Vicksburg, is ably edited by Drs. H. H. Haralson and D. P. Street. The *Record* is neat in its new cover, and we congratulate the management on the general improvement in its columns.

Mortuary.—Dr. P. L. Postell, of Plaquemine, La., died August 3. He was one of the oldest and most respected men in his community. The Journal offers condolence to his bereaved family.

Texas Democrats Favor the Creation of a Health Board —Among the resolutions adopted at the Democratic convention, recently held at Waco, was the following, in which the people of Louisiana are interested:

"We favor the creation of a State Board of Health and provision for the collection of the vital statistics of the State .

"This means that the Legislature has been directed to enact a law creating a State Board of Health to replace the present system, whereby one man has it in his power to absolutely tie up the commerce of the State and of other States on a rumor that contagious disease exists somewhere to the east or west of Texas, which system has been in vogue for many years. The fight for this resolution has been a warm one, and has been carried on without cessation for many years by Dr. Harrison, of Columbus, and other members of the State Medical Asscciation, but not until now have they succeeded in getting the politicians interested in

it. The adoption of the resolution by the Democratic convention, under the system of law-making which prevails in Texas, amounts to a command to the Legislature to pass the law indicated, and as the members of the medical profession of the State and a large commercial interest is interested in its passage, it is quite probable that the Legislature, which is to meet next January, will pass the law which will bring Texas up to date in the matter of public health regulations."

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

The American Year Book of Medicine and Surgery. In two volumes. W. B. Saunders, Philadelphia, 1900.

The era of exhaustive treatises and properly speaking cyclopedias on medical subjects now belongs to our past history. Special monographs, lively periodicals, annuals—like this American Year Book—are the up-to-date instruments practically impossible to be omitted, remitted or spared in our medical studio. Artists and students in "belles-lettres" can treasure up imperishable old books and drink from their contents inexhaustible sources of inspiration. But, we physicians, artists of the hour, we must keep on the run, wide awake, and look to what is coming, rather than to what has gone by or is doing so.

We most heartily commend the book; and it deserves all that can be said of it. DUPAQUIER.

A Cyclopedia of Practical Medicine and Surgery. Edited by GEO. M. GOULD, A. M., M. D., and WALTER L. PYLE. P. Blakiston's Son & Co., Philadelphia, 1900.

As the title suggests, this work summarizes medical and surgical affections, giving in graphic form the skeletal information necessary to the guidance of the busy practitioner. In many instances more complete information is demanded, and so is given. A mass of general items of medi-

cal interest are included, which are extraneous to the title of the book; this, however, makes the volume no less interesting or valuable. A complete directory of the medical practice laws of the United States is found under the proper heading, and under "Poisoning" some twelve pages are occupied, including an elaborate and exhaustive table, forming a synopsis of each toxic agent and its characteristics and antidotes. In many ways this work will fill a need and is commended. DYER.

Lea's Series of Pocket Text-Books; Nervous and Mental Diseases. By CHAS. S. POTTS, M. D. Lea Bros. & Co., Philadelphia and New York, 1900.

Like the rest of this series so far published by Lea Brothers, this volume is arranged with as much conciseness as is possible to make it a handy text book. The material is arranged with a logic method and the book has the merit of being free of personal hypotheses, which makes it the more readily understood. DYER.

Suggestions to Medical Writers. By GEO. M. GOULD, A. M., M. D. The Philadelphia Medical Publishing Company, Philadelphia, 1900.

We have enjoyed reading Dr. Gould's sallies, serious and otherwise, at medical literary effort and style, as these have from time to time appeared in the *Philadelphia Medical Journal*. Dr. Gould has championed both purity and correctness in the usage of medical language while advocating phonetic and logic spelling, in reason. The book before us places most of his arguments in so compact a form as to make them accessible. By no means least interesting is the author's discussion on the "History and Psychology of Words," which closes the book. DYER.

Imperative Surgery for the General Practitioner, the Specialist and the Recent Graduate, by HOWARD LILLIENTHAL, M. D. The MacMillan Company, New York, 1900.

This book "deals only with the diagnosis and treatment of conditions which demand immediate operative measures, and it presupposes the absence of a surgeon and the impossibility and inexpediency of removing the patient or of waiting for expert assistance." This work is admirable in every respect but its intention. If it is intended to educate into competency on the spot any man who is not already able to cope with the difficulties of a serious emergency, then it fails of its purpose, for we all know that it is in just such emergencies that the clearest brain, the stoutest heart and the steadiest hand, all the result of surgical experience, are required. Indeed, even the illustrations, as for instance that on page 42, indicate the most elaborate preparations, such certainly as could not be summoned to the aid of the practitioner removed from the medical cen-

tres. But, viewed from the standpoint of the surgeon, the book will be found very attractive and of the greatest assistance, abounding as it does in clear descriptions and very many valuable suggestions. The author has placed those who operate under obligations, but we very much doubt the wisdom of extending the purpose of the work to those who have not previously familiarized themselves with the use of the knife.

PARHAM.

Lea's Series of Pocket Text-Books; Histology and Pathology, a Manual for Students and Practitioners, by JOHN BENJAMIN NICHOLS, M. D., and FRANK PALMER VALE, M. D. Lea Bros. & Co., Philadelphia and New York, 1900.

The convenient size of this series first of all makes each volume desirable, and moreover the publishers have been honest in the endeavor to get modern matter in the several of the series which have come to us.

The present volume has all the qualities of a text-book; distinctness of presentation; logical arrangement of the text and a sufficient illustration for clearness. Some of the illustrations are excellent, especially those showing pathologic sections and those illustrating the histologic elements.

DYER.

Medical and Surgical Nursing. Edited by H. J. O'BRIEN, M. D. E. P. Putnam's Sons, New York and London, 1900; F. F. Hansell & Bro., New Orleans.

While in many respects this handy volume deals with subjects foreign to the direct office of the nurse and may be open to criticism on this account, it altogether presents a comprehensive text-book on the subjects, worthy of the purpose. Of particular importance are the chapters on General Nursing, Fractures, Dislocations and Wounds, Obstetrics, Poisons, and the final chapter on Cooking for the Sick.

The work is made up of articles from different sources, all, however, written expressly for the publication.

DYER.

Biennial Report of the Board of Health of the City of New Orleans, 1898-1899. DR. S. L. THEARD, Secretary.

The Board of Health of the city of New Orleans has just issued its biennial report for 1898-1899. The report is quite complete, giving an excellent review of health conditions in New Orleans for the two years past. Several extraneous articles are introduced, because written and presented by the officers of the board. These refer to pure water, sanitary methods, etc., and are intended to serve the public. As such they are interesting. and timely.

DYER.

PUBLICATIONS RECEIVED.

Biennial Report of the Board of Administrators of the Insane Asylum of the State of Louisiana, 1899.

Manual of Pathology, by W. M. Late Coplin, M. D.—P. Blakiston's Son & Co., Philadelphia, 1900.

Atlas and Epitome of Diseases Caused by Accidents, by Dr. Ed. Golebiewski.—W. B. Saunders & Co., Philadelphia, 1900.

Atlas and Epitome of Gynecology, by Oscar Schaeffer, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

Manual of Personal Hygiene, edited by Walter L. Pyle, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

Clinical Examination of the Urine and Urinary Diagnosis, by J. Bergen Ogden, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

A Text-Book of Practical Medicine, by William Gilman Thompson, M. D.—Lea Brothers & Co., New York and Philadelphia, 1900.

Biennial Report of the Board of Health of the City of New Orleans, 1898-1899.

The Essentials of Medical and Clinical Chemistry, by Samuel E. Woody, M. D.—P. Blakiston's Son's & Co., Philadelphia, 1900.

International Clinics, by Henry W. Cattell, M. D.—J. B. Lippincott Company, Philadelphia, 1900.

Reprints.

Medical Legislation in Nebraska, by H. Winnett Orr, M. D.

Transportation of the Dead, Board of Health of the State of New Jersey.

What Bearing Has Higher Professional Education on the Work and Welfare of the Manufacturing Pharmacist? by Joseph Helfman.

Pure Food Legislation, Speech of Hon. William E. Mason.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR JULY, 1900.

CAUSE.	White.	Colored.	Total.
Fever, Malarial (unclassified)	4	5	9
" " Intermittent	....	....	....
" " Remittent	2	....	2
" " Congestive	....	3	3
" " Typho	2	2	4
" Yellow	....	....	....
" Typhoid or Enteric	8	4	12
" Puerperal	1	1	2
Influenza	....	....	....
Measles	....	....	....
Diphtheria	2	1	3
Whooping Cough	2	1	3
Apoplexy	6	6	12
Congestion of Brain	1	1	2
Meningitis	6	2	8
Pneumonia	10	7	17
Bronchitis	3	5	8
Cancer	16	3	19
Consumption	34	29	63
Bright's Disease (Nephritis)	20	18	38
Uremia	2	....	2
Diarrhea (Enteritis)	24	11	35
Gastro-Enteritis	8	5	13
Dysentery	1	8	9
Hepatitis	1	1	2
Hepatic Cirrhosis	5	1	6
Peritonitis	....	2	2
Debility, General	....	2	2
" Senile	9	2	11
" Infantile	2	6	8
Heart, Diseases of	24	28	52
Tetanus, Idiopathic	....	....	....
" Traumatic	2	2	4
Trismus Nascentium	8	6	14
Injuries	13	14	27
Suicide	1	....	1
All Other Causes	106	64	170
TOTAL	323	238	561

Still-born Children—White, 29; colored, 22; total, 51.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 18.46; colored, 37.73; total, 22.44.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.03
Mean temperature	81.
Total precipitation, inches	6.08
Prevailing direction of wind, southeast.	

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. OCTOBER, 1900. No. 4.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

TUBERCULOSIS.*

BY J. A. STORCK, M. PH., M. D., PROFESSOR OF DISEASES OF THE DIGESTIVE APPARATUS IN THE NEW ORLEANS POLYCLINIC, ETC., NEW ORLEANS.

Since the times of Hippocrates tuberculosis has been credited with being the most fatal of all diseases, and many of the most eminent physicians for the past 2000 years have devoted some study to this most dreadful malady; but only during the last half of the present century has the subject been given the attention it deserves. Tuberculosis is responsible for one-seventh of all deaths, and when we stop to consider that one-sixth of all mankind are afflicted with it, the time is opportune for the whole genius of the medical profession to unite in an earnest endeavor to prevent, palliate and cure this great enemy of mankind.

It is not my purpose to attempt the exhaustion of this vast subject, but simply to give a brief resumé of what I consider the most salient points in the prophylaxis and treatment; leaving its pathology and bacteriology to other hands.

Whittaker divides the history of tuberculosis into five periods, three of which, at least, are quite distinct, in that they date from

* Read at the meeting of the Louisiana State Medical Society, April 19, 20, 21, 1900.

the discoveries of distinct individuals, Bayle and Laennec, Villemin, and Koch.

The first is the period of ancient history. During all this period the disease was observed from only a clinical standpoint. The second period, beginning with the birth of anatomy, in the sixteenth century, furnishes the first definite knowledge regarding changes or lesions of structure. The third period followed the publication of the discoveries of Bayle and Laennec, in the first quarter of the nineteenth century, declaring tuberculosis a separate affection due to the deposit of tubercle, a specific product independent of ordinary inflammation. This period is made distinctly memorable by the discovery of auscultation as a means of diagnosis. It was the genius of Laennec in the discovery of auscultation which first rendered possible a diagnosis of the disease in life.

The fourth period was introduced late in the last half of the nineteenth century, with the inoculation experiments of Villemin in 1865; and the fifth was announced with the brilliant revelations of Koch, 1882, regarding the cause of tubercle and the etiology of the disease.

It is now generally conceded that the cause of tuberculosis in man is the bacillus tuberculosis, and that its contraction is *usually* by inhalation and ingestion. Dried tuberculous sputum is the most fruitful source of the propagation of the disease.

As the expectoration of tuberculous subjects contains many bacilli, at times, when dried and pulverized, it becomes potent for harm.

The healthy individual has little to fear from the inhalation of the bacilli; but in the subject whose health is below par from any cause, the bacillus, if it once finds a lodging place, is very likely to play havoc, and before he is aware of it tuberculosis has laid hold upon him, and if care be not now exercised, one more death certificate will read "Tuberculosis."

The writings and experimental work of Villemin, Weber, Koch, Tappeiner, Cornet, Kruger, Straus and others, confirm this. Physicians should insist that the careless and promiscuous expectorating of tuberculous individuals must stop. Much can be accomplished by proper education of the public on this subject, and every physician should constitute himself a teacher.

The danger of infection and re-infection must be brought forward and explained to patient, family and friends.

It is claimed that the natives of many places, formerly free from tuberculosis, now suffer from it because of these places being now visited by tuberculous individuals, who have infected the natives.

Cuspidors should be placed on stands in convenient places in institutions where consumptives are treated, or in places where they are employed, and it should be insisted that they use these cuspidors and not expectorate on the floor or other places. All receptacles for tuberculous expectoration should be covered, and contain some reliable disinfectant (sol. bichloride mercury 1-500, or sol. carbolic acid 10 per cent.), or the expectoration received in a cuspidor of some destructible material and afterwards burned; pocket sputum flasks answer a good purpose. They should be cleansed with a solution of bichloride of mercury 1-500 or 10 per cent. carbolic acid solution.

If the tuberculous subject uses a handkerchief to receive the expectoration it should be burned after use, and if this be impossible from any cause (cost, etc.), it should be boiled and disinfected for half an hour in 5 per cent. solution of carbolic acid; handkerchiefs of paper should also be used.

The kissing habit should be discouraged, as we now know that the saliva of the consumptive contains bacilli at times. Separate napkins, knives, forks, spoons, glasses, etc., should be provided for the tuberculous subject, and should be sterilized after each use.

Consumptive men should shave clean, wearing neither beard nor mustache.

The danger of infection by means of communion cups, holy water, Bible kissing, etc., should be pointed out and insisted upon. We have a duty to perform, let us do it without fear or favor.

The physician should take into consideration the danger of mouth to mouth respiration in asphyxiated tuberculous infants and vice versa, also the infection of the infant by tuberculous nurses, attendants, etc.

The dangers from tattooing, ritual circumcision, and through sexual relations, should not be lost sight of.

The tuberculous subject ought not to marry until the disease

has been cured for at least two years. It should be insisted upon that no one be allowed to carry on the occupation of school teacher, dairyman, cigar maker, confectioner, cook, or butcher, who has active tuberculosis, and to this end, Boards of Health should have special supervision over the above mentioned trades, etc.

The possibility of infection, while speaking, should be remembered. Care should be exercised by physicians and attendants when attending cases of surgical tuberculosis, also when handling fresh tuberculous specimens, or performing autopsies on tuberculous subjects.

The tuberculous subject must sleep alone, and if circumstances permit, in a separate room, in upper story of house, with southern exposure, the room to be free of draperies and carpets, etc., and contain only plain furniture, which can be easily and quickly cleaned; bed and bedding, as also the room, should be aired daily; in short, a room properly ventilated and heated should be selected when possible. The raising of dust while cleaning should be avoided.

The danger from caressing domestic pets, parrots and canary birds, dogs, etc., should be pointed out, and the proper authorities have the right to destroy all such animals, etc., when afflicted with tuberculosis.

In cases of intestinal tuberculosis it is, of course, essential to disinfect the stools with a solution of bichloride of mercury 1-1000 made strongly acid with hydrochloric acid.

In cases of death, fumigation of the room with some suitable agent should be insisted upon.

Public Prophylaxis.—With the good will of the physicians the sanitary authorities can accomplish much.

"No preacher is listened to but Time, which gives us the same train and turn of thoughts that elder people have in vain tried to put in our heads before."

The question of compulsory registration of tuberculous individuals is one which should be gone about slowly.

The proper health authorities should have supervision over all institutions where tuberculous subjects are treated and cared for. Separate wards should be provided in our Charity Hospital, and as soon as possible a special building, or part of one, set aside for tuberculous patients.

When practicable, centres of infection should be destroyed.

Circulars of instruction, pointing out sources of infection, should be issued by the health authorities and distributed in every home; in short, every means should be employed to educate the people regarding the danger from infection of this most dreadful disease.

The free distribution of suitable pocket-spittoons to very poor tuberculous patients, and also the free disinfection of rooms occupied by consumptive patients, should be provided for by health authorities.

Stringent laws should be adopted governing hotels and boarding houses where consumptives are taken.

Our medical societies should appoint committees, and the people be asked to form societies for the prevention of tuberculosis. School teachers should be instructed regarding prophylaxis, etc.; proper cleansing of street and railway cars, as also theaters and other public places where people congregate should be insisted upon. Streets should be watered before being swept, and ladies should have their attention called to the danger of long trained street dresses.

The dead bodies of all tuberculous subjects should be cremated, and when this is impossible, we should insist upon the application of some strong germicidal agent to the dead body.

The influence of climate, soil, etc., should be carefully considered, and the danger of poorly ventilated work-rooms, factories and homes should be pointed out and emphasized. It is appalling to witness the number of tuberculous subjects that come to my clinic at the Charity Hospital who are employed in laundries and cigar factories.

A sanitary supervision of factories, work-shops, etc., is imperative.

The fact that syphilis and alcoholism predispose to pulmonary tuberculosis must not be lost sight of, and the unfortunate victims of these conditions should be so instructed. The housing of the poor in damp, badly ventilated and over-crowded apartments is damnable and should be stopped if we are in earnest in our crusade to stamp out consumption.

The public must insist that the school-rooms where our boys and girls receive their education be properly ventliated, lighted

and heated, and that every sanitary and hygienic law be complied with.

The inspection of meat, milk, etc., as also the slaughtering house and the dairy should be insisted upon, and the destruction of all tuberculous cattle, etc., take place.

It is the opinion of Osler and others that primary intestinal tuberculosis in the infant is caused by the ingestion of milk from tuberculous cows. It is the duty of every physician to instruct parents regarding children who are predisposed to consumption. A predisposition to pulmonary tuberculosis may be inherited or acquired. (It is extremely doubtful that consumption is inherited.)

Prophylactic Treatment.—While the child is yet in utero, the mother should be instructed to wear loose clothing, so as to allow of free abdominal and thoracic respiration; should live in fresh air, rest regularly and eat well. The new born should have all of this. Proper respiratory exercises should be insisted upon for mother and child. The inspiratory and expiratory functions should be well performed. It is my custom to look upon every subject with harsh breathing and prolonged expiration as a probable case of incipient pulmonary tuberculosis (before any other signs are present), and I instruct them accordingly.

A cool or cold bath should be taken daily. Lack of humidity often proves detrimental to the health of children and also to that of adults. I attribute the poor health of some laundry operatives to the dry atmosphere in which some of them work. Sun baths should be insisted upon. Where the appetite is poor, we must try every means to improve it, for unless the patient eats, all our efforts count for nothing.

Treatment.—Sanataria and special hospitals have done much to simplify, and prove that much can be accomplished in the treatment of the tuberculous subject.

Proper climate and weather are important, and whenever the patient can afford a change of climate, etc., and his case demands it, it should be insisted upon; but the fact that any one climate is not suitable to every patient should not be lost sight of.

A tuberculous patient of the irritable pyrexial type, with a

tendency to nasal and bronchial catarrhs, will do best in a warm climate with little elevation, Southern California, Florida, etc.

All ordinary cases of phthisis, with no throat complications, especially early cases, will be benefited in high altitudes, such for example, as the mountains of Colorado, Montana, Utah, Wyoming, or Davois and St. Moritzdorf in Switzerland.

An altitude of two or three thousand feet suits many cases: North Carolina, Virginia, Adirondack Mountains.

Every case should be carefully studied before a change of climate is suggested. Patients that feel well in cold weather should be sent to cold climate and vice versa.

Advanced cases should never be sent away from home.

I have passed over the subject of climato-therapy rapidly, as it is my intention to deal with the subject of treatment more from a dietetic and drug standpoint; including, in my remarks, such treatments that can be carried out without the patient leaving his native home.

Many patients that we are called upon to treat for tuberculosis are not in a financial condition to leave their homes, and we, as medical men, have a duty to perform; while I must confess, at times, our task is not a light one when treating this class of patients; still I have seen splendid results in the past five years in private and hospital practice, by having patients observe the ordinary laws of hygiene and sanitation and with appropriate dietetic and medical treatment.

Personally I have had no experience with the pneumatic cabinet in the treatment of tuberculous subjects, but have the word of some careful and conscientious men who have had experience that it is a valuable adjunct in the treatment of pulmonary tuberculosis, especially to relieve the congestion of the lungs so often present.

I have found the morning bath and friction with a coarse towel, along with the use of light dumb-bells and clubs, to answer a good purpose. The dress of the consumptive should be comfortable, and according to the season. For under-garments, Jaeger's or similar sanitary wool suits. Headwear should be as light as possible, and well ventilated; when possible it is best that the head be uncovered.

For women, Lady Hadderton or Jenness Miller or similar systems of dress reform should be recommended.

It is best that the tuberculous subjects abstain from the use of tobacco.

The most important point to consider in the treatment of the tuberculous subject is to get him to eat, and eat the proper kind of food, in sufficient quantities; the appetite of most tuberculous subjects is bad; we must try by every means to get our tuberculous patients to eat.

Try them on eggs, raw, soft-boiled, poached, or in form of eggnog; broiled steak, chops, poultry, sweet bread, raw chopped beef, milk or milk toast, rice, bread a day old, or toasted bread, with plenty of butter, cocoa or coffee; mush, fruits, fish broiled, boiled or baked; broths or soups, oysters, clams (raw), rare roast, mutton, poultry, etc.; fresh vegetables, spinach, lettuce and other salads should be prepared with lemon juice in preference to vinegar. No fried food should be allowed.

Foods like Mosquera beef meal, somatose, etc., are valuable at times when the appetite fails.

The teeth should be carefully looked after, and some antiseptic mouth-wash used, such as diluted solutions of euthymol, listerin, pasteurine, etc.; the tooth brush should be used frequently, and properly sterilized after use.

The building up of the tuberculous subject's system is to be carefully gone about, and the drug that stands at the top of the list for this purpose is strychnin.

I use cod-liver oil only occasionally, and then I watch the bowels carefully, stopping it on the first signs of any derangement. Arsenic is another valuable drug, as is also iron; when I use it I give preference to ferratin, but under no consideration do I use iron soon after a hemorrhage, or when there is a marked hemorrhagic tendency.

Hypophosphites, phosphates, iodoform, ichthyol, creosote and its derivations, and many other drugs, including cinnamate of soda and creosote subcutaneously, have all been used by me with varying success and failure.

The creosote derivatives (carbonate, benzoate, sulphonate of guaiacol), in combination with strychnin sulphate, have yielded the best results in my hands in the treatment of 3000 cases of pulmonary tuberculosis. So much so that I have adopted the following line of treatment in my hospital and private practice:

After giving instructions to patients regarding exercise, food, ventilation, clothing, bathing, etc., I prescribe the following:

℞ Strychnin sulph..... gr. ss.
Guaiacol carbonate..... ℥ii.
M. ft. caps, No. xxiv.
Sig.—One (1) twenty minutes after meals.

I also have them inhale a 40 per cent. aqueous solution of formic aldehide, using from 20 to 40 drops on a piece of cloth twice daily.

As a matter of fact, I treat symptoms as they arise.

For night sweats I have found camphoric acid to act well when atropin, aromatic sulphuric acid, oxid of zinc and other agents have failed. I give ten grains of camphoric acid dry on the tongue at bed time.

If cough is troublesome, I give codeine sulph., acid sulph. dil., spts. chloroform, syr. pruni virg.

For vomiting I use cocain hydrochloride and menthol in aromatic elixir.

For the intercostal neuralgia, hot water compresses, counter-irritants, morphin ⅛ gr.

For hemoptysis, ext. hydrastis canadensis fld., morphin sulph., ergotin, atropin sulph., ice.

For the fever, lactophenin 5 to 10 grs., phenacetin 3 to 5 grs., acetanilid 3 to 5 grains.

Nux vomica, cinchona, calumba and gentian are often of much value in improving the appetite.

In advanced cases little is to be done, enemata of Debove powder, blood, yolk of eggs, pepsin, etc.; rest; morphin hypodermically.

The main consideration I wish to bring forward in this paper is the curability of tuberculosis.

Laennec, Charcot, Brouardel, Goodhart, Weber, Kurbow, Nicholas and hosts of others believed that tuberculosis is a curable disease; most careful observers are of the same opinion at the present time.

The appended table of statistics tells its own story:

Reported by	Number of autopsies.	Number of cases where autopsy revealed healed Pulmonary Tuberculosis lesions.
Boudet, of Paris	135	116
Beaux, of Paris	166	157
Bennet, of Meuton	73	28
Baudet, of Paris	197	10
Marsini, of Basel	228	89
Bolinger, of Munich	400	69
Heitler, of Vienna	16,562	789
Chiara, of Prague	701	78
Flint, of New York	670	75
Loomis, of New York	763	71
Letulle, of Paris	189	92
F. P. Weber, of London	.....	29
Ormeroth, of London	.....	50
Vilbert, of Paris	131	17
Fowler, of London	1,943	177
Martin, of London	445	42
Jos. Coats, of Glasgow	103	25
Rogée, of Paris	.....	51 per ct.
Standacher	.....	27 "
T. Harris, of London	.....	39 "
Fürbringer, of Berlin	.....	10 "
Renvers, of Berlin	.....	30 "
Bugge, of Christiana	.....	27 "
Osler, of Baltimore	.....	7.5 "
Walker, of Chicago	.....	4 "
H. M. Biggs, of New York	.....	30 "

At the Chestnut Hill Hospital for the Consumptive Poor, in Philadelphia, patients even in the very advanced stages are received. Still the institution reports the following results:

Discharged as cured ..... 8 per cent.
Improved ..... 11½ per cent.
Unimproved ..... 6⅔ per cent.
Died ..... 17⅓ per cent.

Statistics from four institutions in France and one in Denmark show the following:

Location.	Reported by	Mortality.	Cures.	Improved.	Average Stay.
Ormesson	Dr. Jaoul	8.2 pr. ct.	34 pr. ct.	30 per cent.	7 months.
Villiers	Dr. Vaquier	8.8 pr. ct.	25 pr. ct.	34.4 per cent.	
Forges les Bains	Dr. Dumenge	.....	50 pr. ct.	25 per cent.	12 months.
Arachon	Labesque	29 pr. ct.	21.7 pr. ct.	45.9 per cent.	
Refsnaes (Den'k)	Shepelern	.....	25 pr. ct.	42.4 per cent.	8½ months.

Dr. Hermann Biggs, the director of the New York City Department of Health, in an article on the prevention and restriction of pulmonary tuberculosis, which appeared in the June *Practitioner* (London), 1898, produced the following table,

showing the decrease in the death rate from all tubercular diseases in New York City during the past twelve years:

	1886	1887	1888	1889	1890	1891	1892	1893	1894	1895	1896	1897
Death rate	4.42	4.06	3.99	3.86	3.97	3.56	3.55	3.51	3.16	3.34	3.06	2.85

That pulmonary tuberculosis is a curable disease under certain conditions is my firm belief. If we can instil hope of recovery in our patients we have accomplished much.

Carswell, 1838, wrote.

"Pathological anatomy has perhaps never given more decisive proofs of the curability of a disease than it has given for pulmonary consumption."

In conclusion I desire to express my sincerest thanks to Dr. S. A. Knopf, of Bellevue, N. Y., for invaluable assistance.

PROPHYLAXIS OF SURGICAL SHOCK.*

By W. M. PERKINS, M. D., Assistant to the Chair of General Clinical and Operative Surgery in the New Orleans Polyclinic, New Orleans.

In the aggressive surgery of the close of the century when, under anesthesia and with aseptic precautions, operations involving long forbidden areas and lengthened periods of time have become quite common, the prevention of the shock which so frequently complicates such cases becomes of paramount importance. Often at the beginning of an operation the patient's general condition is practically normal, and yet afterwards the main source of anxiety is the collapse apparently imminent. The long technic of modern asepsis and the thoroughness encouraged by an apparently satisfactory anesthesia tend to increase the danger from this source. The importance of perfecting the prophylaxis of shock is now attracting more general attention, and yet the precision of pre-operative measures is constantly increasing.

Among the widely different causes to which shock has been attributed are molecular vibration, cerebral anemia, cardiac failure, passive abdominal hyperemia, general vasomotor paresis, and reflex inhibition.

*Read at the meeting of the Louisiana State Medical Society, April 19, 20, 21, 900.

Crile's conclusions as to the importance of the vasomotor system in the production of shock, based as they are upon extensive laboratory research, are valuable and suggestive, especially from a prophylactic point of view. In more than one hundred cases he found that the vasomotor centres, although depressed by the same causes, were more easily affected than either the respiratory or cardiac, and that shock was most satisfactorily overcome by measures increasing vascular tension.

Cardiac failure was most always dependent upon lowered blood pressure or impaired respiratory action, and the pulse could usually be restored when the other two difficulties could be overcome. Vasomotor failure affected the heart's action not so much by starving its muscle-fibres or its controlling ganglia, as by lessening the intravenous pressure, and thus depriving the organ of an adequate supply of fluid to act upon.

Lowered blood pressure necessarily impairs the nutrition of the vasomotor centres, increasing the vascular dilatation, and the pulse is accelerated by the effort of the heart to compensate for the diminished amount of blood ejected at each stroke. The demand of the tissues for so much nutrition per minute increases the pulse rate through reflex stimulation. Whenever the heart's action is accelerated in its effort to restore arterial tension, or by deficient oxygenation of the blood, its controlling centres may become exhausted by overstimulation. These cells also suffer from the toxic action of anesthetics, and are starved when the blood is lacking oxygen or its pressure is deficient. Heart failure may be due to inhibition or exhaustion of the cardiac centres as well as from diminished blood pressure.

The respiratory centres are affected by the same causes, but are much more liable to depression than the cardiac. When they are poorly nourished deficient oxygenation increases the shock. Diminution in the quantity and quality of the blood affects not only the respiratory central nerve cells, but also the fibres of the essential and accessory respiratory muscles, which lose their normal contractility. Sensibility is markedly diminished when shock is once thoroughly established, and the reflexes essential to normal respiration and circulation may be lost. A vicious circle is sometimes thus established, which tends to ultimate collapse.

There is abundant experimental evidence to prove that over-

stimulation of any portion of the nervous system tends both to exhaust and to inhibit the great vital centres. Crile has shown that a potent cause of such inhibition or exhaustion is manipulation of important nerve trunks in any part of the body or irritation of any portion of the vagus nerve or its branches. He also found that the danger might be lessened by cocainizing the nerve trunk or filaments in question. (This is in line with Rosenberg's plan of cocainizing the nasal mucous membrane to prevent cardiac inhibition in the early stages of chloroform anesthesia.) Crile found intralaryngeal manipulation especially prone to induce this inhibition. It is possible that this danger might be overcome by a rapid preliminary cocainization of the larynx through a specially devised atomizer tip with lateral openings and suitable curves. The irritation and chilling of tissues from long exposure during operation, excessive hemorrhage, prolonged anesthesia, rough manipulation—all these tend to produce shock.

Briefly, then, shock seems to consist essentially of a central nerve depression due to the exhaustion induced by long-continued or violent stimulation, and manifesting itself in symptoms referable to three main causes, viz: (1) a vasomotor paralysis; (2) a respiratory paralysis; (3) a cardiac paralysis. Crile has especially insisted upon the difference between collapse and shock. The former he defines as immediate depression or death from injury or operation caused by cardiac, respiratory, hemorrhagic and vasomotor factors; and the latter as a delayed depression or death mainly due to vasomotor failure, though any of the other factors may be of considerable importance. Inhibition is probably the most potent factor in collapse, while in shock exhaustion plays the more important part.

When the nature of the case will permit careful pre-operative prophylaxis, the liability of surgical shock may be greatly diminished. It is highly improbable that all the precautions suggested, or even a majority of them, can practically be applied to any one case, but in prophylactic as in all other treatment the personal judgment of the surgeon must determine what would be superfluous. With the treatment of shock once established, it is not the purpose of this paper to treat.

Since surgical shock is produced by exhaustion of nerve centres, nothing could be more rational than to advise a period

of rest prior to severe demands on those cells. Therefore, in preparing for the extraordinary strain of an operation, all fatigue, whether mental or physical, should be avoided. The twelve hours immediately previous should always be spent in bed, and this final rest should be broken as little as possible by either transportation or preparation. With debilitated patients the necessity for these precautions is increased, and no unnecessary exertion should be permitted. It is unwise for the patient to walk to the table before a severe operation.

When practicable, the final purgative should be given at least twenty-four hours prior to operation, that the final rest may not be broken by frequent evacuations. Physical rest should be as perfect as circumstances will permit. Especially should the patient be relieved of all unnecessary discussion of his own case, and no attendant should be permitted whose manner or conversation is calculated to excite the patient. It is particularly essential that the patient should feel confidence in the surgeon, and should not be oppressed by fear. Since extensive preparations often excite alarm, it is advisable to make the details as simple as practicable ; and it may even be better in some cases to complete them under anesthesia, especially when pain is involved.

The patient's general condition will be greatly benefited by restful and abundant sleep for the few nights preceding the operation, and the last night's rest should be as perfect as possible. While natural sleep is far preferable, hypnotics may sometimes be useful when there is no special contraindication. The morning is preferable for severe operations, as it follows closely the night's rest, and the vitality is usually at its highest daily point. Nutrition should be promoted by several days of wholesome feeding, so planned that neither will the digestive organs be overtaxed nor the body cells be underfed. A gentle flushing of the kidneys is a good preparation for any severe operation, and the free use of water for several days at least should be urged. Where renal disease exists, mild diuretics may well be added. The important role of the kidneys in eliminating toxic substances from the blood renders it essential to have these organs functioning as perfectly as possible.

Bouchard, to whose valuable work we are indebted for much of the present knowledge of auto-intoxication, has urged the

necessity for a preliminary abstinence from animal food in order to diminish the toxic waste products to be eliminated by the kidneys. That the skin may be as physiologically active as possible, baths and frictions may sometimes be advantageously employed for several days. Of course, no patient should ever go to the table without at least one full bath, unless some special contraindication exists.

Besides the rest and other general measures suggested, some special means may be employed to prepare the three great nerve systems, the cardiac, the respiratory, and the vasomotor, for the extra demand to be made by anesthetics and operation. Should there exist any cardiac or pulmonary pathologic condition amenable to treatment, it should be treated as thoroughly as practicable. A course of cardiac stimulants might be advantageously employed with patients suffering from functional or organic disease of the heart. All inflammations of the respiratory tract should be relieved as completely as possible. Loose clothing and an abundant supply of pure air should be urged during the last few days. A condition of lowered vascular tone might be improved by a preliminary course of such remedies as will later be mentioned as stimulating the vasomotor centres. In dealing with weak patients a preliminary course of alcoholics, strychnin and digitalis may be profitably employed. Overstimulation should be carefully avoided, but much good may be accomplished by judiciously regulated doses, when impaired circulation is poorly nourishing the nerve centres.

Binz, while supervising the moving of wounded during the Franco-Prussian war, went about with a syringe and a bottle of morphin solution. He found that patients thus treated stood transportation far better and suffered much less from shock. Nothing could be more rational than to give a hypodermatic of morphin immediately after injuries on the battlefield or elsewhere. Experimental and clinical evidence show so conclusively that pain, fear and excitement are such potent factors in producing the cell exhaustion which has already been pointed out as the essential cause of shock, that the morphin in such cases seems almost as clearly indicated as quinin in malaria.

It may not always have been practicable to carry out the general prophylactic measures previously discussed, but much may be done to lessen the liability of shock, even after the patient is

placed upon the operating table. In preparing to avoid shock, the question of anesthesia will demand careful consideration. Schleich's infiltration method, Corning's nerve trunk anesthetization, Bier's spinal injection, and the substitution of eucain for cocain, have all aided in enlarging the field of local anesthesia and correspondingly eliminating one of the main causes of shock in many cases. When because of the extent of the operation, the locality, the physical condition of the patient, or for any other reason a general anesthetic has been chosen, ether is preferable to chloroform in the absence of any renal, bronchial or other contraindication. It has been found to be less depressing. To avoid the muscular exhaustion from struggling during the stage of excitement the anesthesia may be begun with nitrous oxide and continued with ether. This plan succeeded admirably in an operation for strangulated hernia in an aged female performed in New Orleans by Parham some months ago. The narcosis should never be unnecessarily prolonged or deepened, but intermittent partial recovery should be avoided also, as excess of the vapor may easily be inhaled by the deepened respirations of this condition. The anesthetist should be consulted before measures liable to make fresh demands upon the vitality of the patient are undertaken.

About twenty minutes before beginning the anesthetic it is well to give hypodermatically morphin sulphate ¼ grain, with atropin sulphate 1-150 to 1-60 grain, to which may be added strychnin sulphate 1-30 grain. The morphin allays both pain and excitement, and renders anesthesia easier to establish and maintain. The strychnin may be repeated during the operation when the pulse begins to flag, or in long operations, even when there has been no manifestations of exhaustion. Doses of 1-60 to 1-30 of a grain frequently repeated are preferable to larger doses unless the threatening symptoms necessitate more vigorous stimulation. By central stimulation strychnin strengthens the heart-beat, deepens the respiration, and raises and maintains vascular tension. The atropin acts as a powerful cardiac and respiratory stimulant, and is of especial value in preventing cardiac inhibition. Tincture of digitalis may be given by needle in doses of from 5 to 25 minims when the pulse begins to be irregular or weak. It steadies, amplifies and slows the cardiac impulse and raises arterial tension. It must be used sparingly where the arteries may be calcareous.

Threatened respiratory failure may often be averted by stopping the anesthetic and inverting the patient. When menacing symptoms continue in spite of hypodermic medication and cessation of anesthetic, the head should be lowered and the lower limbs and pelvis raised. A large quantity of venous blood is thus thrown into the thoracic veins, and the pressure in the cardiac feeders is greatly increased. Besides, the intracranial circulation is facilitated. Sometimes when unfavorable symptoms recur as the patient is returned to the horizontal position partial inversion may have to be maintained for a long time.

Ammonia by inhalation, hypodermatically or even intravenously, is an efficient stimulant and acts almost immediately. Alcohol, while a valuable aid in preparation and post operative treatment of patients, is of very little value during anesthesia, and may even deepen the narcosis. Although contraindicated in profound shock, inhalations of amyl nitrite, 5 to 10 minims, are often of inestimable value when sudden collapse threatens. When some intrinsic cardiac weakness exists, as fatty degeneration, and especially when a full pulse rapidly becomes weak, the strong probability of reflex inhibitory causes justifies the use of this powerful vasodilator, because it also powerfully opposes reflex phenomena, besides increasing the intracranial circulation. When advisedly used, its beneficial effect is too immediate to leave any room for doubt.

Saline infusion is not only a most satisfactory means of combating shock already established, but is also an efficient prophylactic agent. This is true when there has been no loss of blood as well as after severe hemorrhage. Whether the blood actually escapes from the vessels or the vessels themselves dilate, the effect on blood pressure is the same. In vasomotor paralysis the blood accumulates in the veins, which offer less resistance than the arteries, and the tissues are bled just as effectively when the blood accumulates in the abdominal veins as when it leaves the body. The value of intravenous infusion in the treatment of shock produced or accompanied by hemorrage has been thoroughly recognized, but not for bloodless shock. In the clinics of Dr. Parham, who, in an article in the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, in 1898, advocated prophylactic infusion, the writer has repeatedly observed the beneficial effects of infusion, not only for shock without hem-

orrhage, but also when given just before and during the more severe steps of operations in which shock was essentially feared. When the patient was weak or the operation formidable, the insertion of the canula before beginning the operation often saved valuable time when the pulse flagged. It was often left *in situ* for repeated post-operative infusions. Filling up vessels just beginning to dilate may avert disaster by reversing the "vicious circle" mentioned above, and the blood-pressure being maintained the central depression and inhibition may be more readily overcome.

The profuse perspiration which so often follows hot saline infusions may speedily remove from the vessels a not inconsiderable amount of fluid. Atropin will be of service in preventing this. The various stimulants discussed may be introduced directly into the circulation in the infusion when an especially rapid action is demanded.

Dangerous symptoms are less likely to arise when proper precautions are taken. Besides those already mentioned, all unnecessary exposure, chilling, or handling of tissues would be avoided, especially in the regions where reflex inhibitions are most likely to be started, such as the neck, axilla, and in the abdomen, usually near the pylorus or diaphragm. The writer has seen two cases in which alarming symptoms followed manipulation of or near the pylorus. In one, a pyloroplasty, the respirations ceased entirely whenever the pylorus was lifted, to be resumed only when it was allowed to drop back.

Speed must be recognized as an essential to successful operation. Prolonged anesthesia alone may cause death. Blunt dissection, so frequently the refuge of the timid surgeon, tends to produce shock by the tearing of nerve fibres. The importance of maintaining the temperature of the room, the patient and the solutions should never be forgotten.

Nothing that tends to diminish the dangers of severe operations can be too insignificant to command the attention of the surgeon, for each step toward a perfected prophylaxis, however small, has its intrinsic value in terms of human life.

Clinical Reports.

A CASE ILLUSTRATIVE OF THE ABSENCE OF THE ORDINARY ACUTE TYMPANIC SIGNS IN ACUTE SUPPURATIVE MASTOIDITIS FOLLOWING ABSCESS OF THE MIDDLE EAR—OPERATION—DEATH.*

BY C. J. LANDFRIED, M D., NEW ORLEANS.

My only apology for this report is the interest of an observation that I was able to make in a case of otitis media acuta suppurativa, which terminated in mastoiditis, requiring operation on the mastoid, the case terminating fatally from a general pyogenic infection of the brain, and metastasis in the arms and legs. The lady, white, about 45 years of age, applied to me through the advice of her physician, for treatment, etc., of an inflammation of the middle ear of the left side. She gave me the history of having taken sick at her home in the country with a severe pain in the ear and marked constitutional disturbance, *i. e.*, anorexia, fever, and general depression. The family doctor was called in, who prescribed the application of poultices. He did not have the facilities for examining the interior of the ear or for treating it surgically. The lady continued with that treatment and the use of anodynes given systematically by the doctor for two weeks. At the end of that time she came to New Orleans and applied to a local physician, who was not a specialist, but finding that she was not suffering from any troublesome ear ache, and that the discharge was free, he prescribed an antiseptic wash and continued to observe her for two weeks. At the end of that time she complained to the doctor that the ear was beginning to hurt again, whereupon he advised her to call on me. Upon examination at my office I found the drum membrane somewhat infiltrated, of a dull purplish color, not bulging, and perforated in the superior-posterior quadrant by an opening as large as the head of an ordinary pin, with a trickling of pus through it which was not profuse. There was not redness enough in the drum membrane to indicate a condition sufficiently acute to be the

*Read before the Louisiana State Medical Society April 19, 20, 21, 1900.

cause of much pain, nor was there any evidence of periostitis of the external canal near the junction of the tube with the drum membrane, which so often happens when middle ear abscess is destined to cause complicating conditions of a grave character. There was neither any bulging of the membrane that would indicate tension in the drum cavity from deficient drainage of pus or other secretion of foreign matter. Notwithstanding this apparently benign condition of symptoms obtained by the objective examination, I advised the physician in attendance here of the possibility of the continuous suppuration coming from an inflammation of the cellular cavities beyond the middle ear, and that it would be well to enlarge the opening in the drum membrame, thereby giving the patient benefit of any doubtful freedom in the drainage of septic or other matter. The doctor and the patient consenting, chloroform was given her, and the membrane incised from the lower to the upper margin, behind the line of termination of the long process of the hammer, the knife being carried well up to the ring of the bone to which the drum is attached and drawn out through the tissues and periosteum of the external auditory canal, where it joins the drum for a distance of about one-eighth of an inch. Incidentally, I may say that the patient stopped breathing for a while during the administration of the anesthetic, and became cyanotic, but she recovered by pulling out the tongue and lowering the upper portion of the body. Finally, a strip of iodoform gauze was put in the auditory canal and the patient let alone until I saw her the next morning at my office. From this time on I saw her every day, washing the ear (external auditory canal) with a warm boracic acid solution and blowing out the pus by the aid of the Politzer bag. There was really no change for the better or worse in the objective signs or the subjective condition of the patient until three weeks afterwards when a trail of complications presented themselves.

Only two days before the onset of the condition presently to be related, which was ominous to me of the dangerous state of affairs that the patient was now fast making for, she began petitioning me to let her go to her home in the country, as she could wash the ear and observe the general antisepsis of the external auditory canal as I had been doing every day, and that she felt no need of remaining here. I was actually about to

agree with her, as neither the tympanic signs nor other regional or constitutional symptoms were at all indicative of the impending danger when, in the two days that it appears to have taken me to conclude whether or not I would consent to her going, she applied at the office complaining of her having suffered pain in the side of the head. There was some tenderness on rather hard pressure over the mastoid and a slight tumefaction in that region, with a little redness of the skin. The tympanic signs, however, were not proportionately aggravated; in fact, they were not changed at all, except for a slight increase in the amount of pus coming through the opening in the membrane. I advised her to go to her room and apply an ice bag to the mastoid region, and gave her a prescription for a few doses of phenacetin and sulfonal for the relief of an increase of temperature or pain; the temperature at the time being 100 deg., which was the incipiency of the pyrexia during the whole course of my observation of the disease in her case; in the evening the temperature had gone up to 102 deg., and the pain had become so great that I was compelled to order some morphin to be given during the night. About 4 o'clock A. M. she sent for me because of the intense suffering in the head and neck. I insisted upon her going to the Sanitarium at once, but she could not arrange her affairs with her relatives to do so, and she did not get there before the afternoon, after Professor Matas had seen her with me at her home at noon, and who persuaded her not to delay in submitting to the operation of opening the mastoid antrum and cells. The temperature was then 103 deg. I prepared for the operation, and with the kind and able assistance of Drs. Gessner and Backus, chiseled into the mastoid antrum at 8 P. M. that day. I had no trouble in finding the antrum by chiseling through the supra-meatal triangle, going about three-quarters of an inch inward and forming a communication with the middle ear. The pain during the preceding night and up to the time of operation having been so great, and the temperature so high, I necessarily felt greatly surprised not to find pus in the bone as I chiseled through it. I finally completed, however, what I thought to be an operation that would be followed by great and steady amelioration of the urgent condition, if not by complete or early recovery. The next morning the temperature was 101 deg.,

and the pain very much less, the patient having had a rather restful night. At my evening visit the temperature was again 103 deg., and the pain in the head intense and becoming worse. I removed the dressings and irrigated the wound. I found the opening in the bone to be filled with pus, which bathed also the surrounding soft tissues. The next day the patient's condition not having improved, and the tumefaction having extended lower toward the neck and backward in the occipital region, I considered it necessary to do a secondary and more extensive operation and asked Prof. Matas to see the case with me, which he kindly did. Upon examining the head, we found it necessary to carve out all the mastoid process, exposing the lateral sinus for about two inches of its course. The sinus appeared rather tense and full, and we deliberated about the advisability of ligating the jugular vein and opening the sinus and flushing it out, but refrained from that procedure because of the free flow of blood through an aspirating needle which Professor Matas very ingeniously passed into the sinus to determine whether or not there was thrombosis. There was no swelling in the neck in the region of the jugular vein, nor any other evidence there to indicate that that structure was inflamed. In the chiseling away and removal by rongeur, etc., of what remained of the mastoid bone, considerable pus was found to ooze from the cellular bony spaces, which were followed up until the whole area was cleared of anything that we thought could keep up further disturbance. The bony external auditory canal was removed in its entire posterior wall, thereby making one large space of the mastoid area, antrum and middle ear. Strange as it may seem to the aurist, this extensive removal of bone was not accompanied by injury to the facial nerve. For two days after this operation the temperature showed a tendency to be more controllable, though we had still to use small doses of phenacetin to keep it below 103 deg. At the end of this time the temperature went up to 104.8 deg., and patient complained of excruciating pain in the knee. She was sponged, which brought the temperature down to 102.2 deg. in about two and one-half hours, when the sponging was discontinued, especially because of the chilliness of which she complained, and because of evidence of bad circulation through the superficies. She was given quinin, five grains every three

hours, with one-sixtieth grain of strychnin and ten drops of the tincture of digitalis. The pain in the knee continued to be intense enough to require the use of morphin hypodermically at regular intervals. On the morning of the fourth day following the second operation she complained of pains in the lower abdominal region, and explained to the nurse that she was pregnant, whereupon a message was sent to Professor Matas and me and the patient was delivered of a twin five or six months' pregnancy. There had not been any observable abdominal evidences of pregnancy and she had been anesthetized three times during this illness without any consideration or knowledge of the existence of that condition. The ordinary treatment, especially the antiseptic precautions, were observed for her lying-in condition, and she seemed to have no trouble from that source. She developed the same character of pain in the deep structures of the forearm as she complained of in the knee; in fact, she suffered so much that Professor Matas incised the soft tissues down to the bone, going through the periosteum. Ordinary antiseptic dressing was applied. The painful extremities were put up in plaster bandages so as to immobilize them and thereby lessen the pain, which the patient had complained of so terribly. The temperature had continued above 100 deg. all the time, averaging 102 deg., finally going up to 106 deg. a few hours before death, which occurred on the ninth day after the first operation, and six weeks after the beginning of the ear trouble. The corneæ became hazy and devoid of reflex; the breathing became bad and the patient comatose about two days before she died. One day before she died, and when she was probably moribund, the internal jugular vein was ligated and the lateral sinus opened, but no thrombosis or evidence of pyo-phlebitis could be found.

CONCLUSIONS.—1. We had better depend upon the presence of pus coming continuously through a perforated drum in determining the possibility of mastoid complications coming on, rather than upon those intensely acute objective tympanic signs ordinarily seen when the complicating disturbances occur.

2. The danger of delay in operating on the mastoid in cases occurring late in the history of otitis media acute where suppuration has been continuous, as well as the necessity for better equipment on the part of the profession who have to do their

special as well as general work; at least an equipment that would allow the doctor to incise the drum membrane and arrest the infectious invasion of the mastoid cells or other deep structures. Numerous observations have demonstrated the incomparably better results in cases where the drum was incised, and not ruptured by the tension of the inflammatory products of the middle ear. My own observations have taught me to err, if err I should, always on the side of incising the drum. A large incision made early is one of the most conservative things I know of in surgical practice.

3. It is not safe to chisel only into the mastoid antrum. The complete carving of the mastoid process, even if the sinus should be exposed in the attempt, had also better be done in every case, as recommended by Dr. Schwartze and accepted as best by aural surgeons in general.

4. The assistance the aspirating needle may be to the surgeon in determining whether or not it is imperative to open and flush the lateral sinus as well as determine the necessity of ligating the jugular vein. When there is no thrombosis the blood will flow through the needle passed into the sinus.

5. Prognosis in any case of running ear with reference to complications is uncertain until all the discharge has ceased.

In conclusion, I desire to express my sincerest thanks for the valuable assistance of Professor Matas, whose clear judgment in the management of the case saved me the heartaches we experience when, after the death of a patient, we feel that we ought perhaps to have done more; I wish as well to thank my kind colleagues, Doctors Gessner and Backus.

THREE SUCCESSFUL CASES OF HIP-JOINT AMPUTATION BY THE METHOD OF WYETH.

By F. W. PARHAM, M. D., Professor of General Clinical and Operative Surgery New Orleans Polyclinic.

Case I.—(This case has already been reported in the *Journal of the American Medical Association*, December 23, 1893.)

Male child, 3 years of age, suffering from recurrent sarcoma of the soft tissues of the thigh. Several operations had been previously done, involving the soft parts only. The infiltration of the tissues of the thigh, and the history of rapid recurrence

after the several previous operations, convinced me of the futility of any operation short of disarticulation of the hip-joint. Accordingly, this operation was done. Operation, October 5, 1893, at the New Orleans Sanitarium, by Wyeth's method. Ordinary mattress needles were obtained for the sum of 20 cents a piece. These were prepared by cutting off one of the sharp ends and properly filing. The needles being then brightened by the use of sand paper were easily made aseptic by boiling.

The outer pin was placed a little too low and this interfered somewhat with the disarticulation, thus prolonging the operation unduly, but the exsanguinating action of the tube was very satisfactory, the amount of blood lost being insignificant, certainly not over two ounces during the whole operation. Even less would have been lost had it not been necessary, owing to the outer pin's being too low, to take away the tube in order to catch some of the higher spurting vessels. I believe it a decided advantage to put both pins so high that not only the vessels in the circular cut can be secured, but that the disarticulation shall be completely done, before the constricting tube shall have to be taken off. No bleeding, then, goes on while the neck and head of the bone are being dissected away from the socket. The child recovered well from the operation and did well afterwards, the stump being closed in in two weeks and complete cicatrization of the skin wound having taken place on the nineteenth day. He died during the following April, from the best information received, most probably from extension to the lungs.

CASE II. J. C., aet. 20, a native of Mississippi, was admitted to my service in Charity Hospital on February 16, 1896. Said he had had trouble in his thigh for three years, and that it had recently gotten much worse. Examination of the limb showed extensive disease of the whole thigh. There had evidently been a severe osteomyelitis of the femur, which had completely disorganized the bone and, breaking through the bone into the soft tissues, had set up extensive suppuration, which extended from trochanter to knee, and involving the knee-joint. He showed marked anemia from the prolonged septic process, and his condition generally was decidedly bad, certainly not offering an inviting prospect for a radical removal of the disease by excision of the whole femur. However, something had to be done.

February 18. Under anesthesia I did a rapid circular amputation up in the thigh, but still through diseased tissues; the soft tissues were thoroughly scraped and the bone cavity curetted out and packed with iodoform gauze. Following this operation there was steady improvement, so that in two weeks, that is, on March 5, 1896, disarticulation could be safely done. It was done with the aid of the mattress needles. The loss of blood was insignificant and his recovery uneventful. He was discharged May 2, 1896.

I believe the plan pursued in this case of doing the operation in two stages, as it were, was largely instrumental in bringing about the happy result.

Case III. May Clement, female, aged 5 months, admitted into my children's service October 20, 1899, presented the following history:

The mother, a woman 38 years of age, seems in good health and says she has always been well. She has had four miscarriages, but has never had any trouble with her full term children, nor has she observed any thing wrong with any of them until the birth of the last, our little patient. Examination of the mother revealed nothing beyond a slight chronic endometritis with some leucorrhea. The father seems to be a healthy, hard-working man with no family history of cancer or any syphilitic disease.

The mother relates that, three weeks before the birth of the child, whilst walking rapidly she collided with one of her sons, who was carrying an armful of wood. She received the full force of the collision above the right inguinal region. This blow caused some pains which kept her in bed for a few days. On May 16, 1899, the child was born, the presentation being of the vertex and the labor quick and uncomplicated. The child seemed well developed and weighed six pounds. The only thing that seemed wrong was a swelling on the outer side of the left knee. This was evidently semifluid in character and appeared to the attending physician to be a hematoma. Little attention was paid to this until it was noticed to enlarge steadily, accompanied by some fever. Believing it to be pus, an incision was made at its most prominent point; nothing, however, escaped but a bloody fluid. This incision healed very quickly, but a new impetus seemed to be given to its growth, as it now increased

more rapidly in size, so that at the age of three months it had involved the entire knee, encroaching upon the thigh and leg.

This was the condition on admission, the knee being quite prominent and deformed by a large fluctuating mass, which occupied chiefly the internal aspect of the knee. Although the tumor evidently contained some fluid, its general appearance and the history of its growth favored the idea of malignancy. The temperature was slightly elevated from an attack of enteritis which had developed just before admission and had not yet gotten well.

The child was rather feeble, so it was put upon strychnia, digitalis and Ducro's Elixir in preparation for an amputation which had been determined upon.

The child's condition seeming now to justify the operation, on October 27, 1899, she was carried to the hospital amphitheatre and a hip-joint amputation done under chloroform by Wyeth's method. Ordinary glass-headed ladies' hat pins were used instead of the regular pins of Wyeth. A circular cut was made, followed at once by the longitudinal incision along the trochanter. Lifting the flaps by rapid dissection the joint was soon reached and the bone disarticulated with little difficulty, using the unsawed femur as a lever, as suggested several years ago by Murdoch, of Pittsburg. For the constricting bands a piece of small rubber drainage tubing was employed. A towel was held over the anus to protect the field of operation from contamination by the fecal discharge which continued during the whole operation. The amount of blood lost was small, certainly not over one ounce from first to last. Especial care was given to the closure of the inner aspect of the wound, owing to the proximity of the anus, and a thick dressing was applied to protect it still further from urinary contamination.

It is worthy of remark that the tiny patient, weighing not over seven pounds, and hardly bridging over the Kelly pad in which she was placed, stood the operation well, and was sent back to the ward, nearly two blocks from the operating amphitheatre, after this trying ordeal, lasting not quite half an hour, in excellent condition. The shock was by no means pronounced. Later in the afternoon the child lost color and showed signs of shock. The temperature began to rise shortly after the operation, and within a few hours had reached 104.8 deg. F. Spong-

ing quickly brought it down below 100 deg. It rose soon again but was as quickly reduced by the sponging, which seemed to have a most happy effect. This continued until next morning when I made my morning visit. I dressed the wound, removed the drainage tube and cut one suture in order to relieve tension. In spite of this the temperature continued all that day, the following night, the next day and night and until the morning of October 30, but always showing not so high a tendency. Several sutures were now removed and the stump opened up discharging some pus. The temperature fell perceptibly after this, but rose again on November 1, when the stump was more extensively opened up and packed. By the third of November the fever had about subsided and convalescence set in. She was discharged November 15, 1899 in excellent condition, only a slight superficial ulceration remaining. Active stimulation had been kept up during the period of depression by means of strychnin, digitalis and brandy, morphia in infinitesimal dose being occasionally given for pain. The child nursed the mother's breast immediately on returning from the operating room and did so at short intervals subsequently.

The rapid elevation of temperature was most probably due to shock, which set in soon after the operation; then sepsis manifested itself in spite of the precautions taken to prevent it. It was undoubtedly due to contamination from the diarrhea.

The report of the pathologist showed the structure of the tumor to be that of a small round-celled sarcoma with myxomatous change.

A personal communication from the attending physician August 31, 1900, showed the child to be well and free from any recurrence. (For the notes of this case I am indebted to Mr. Seemann, the interne, at that time in charge of the Children's Service.)

These three cases I think demonstrate that by the use of the method of circular constriction at the level of the hip-joint by the aid of Wyeth's pins, one of the causes, hemorrhage, of the former great mortality from this major operation may be done away with. Shock also is minimized, for we all know that a small amount even of bleeding will add much to the shock arising from the operation. Further, we believe it is now a well-established fact that susceptibility to infection may be acquired through the

shock following severe operations. In a recent interesting article prepared for the Thirteenth International Congress and published in the *Medical Record* of August 11, 1900, Fenton B. Turck dwells upon this influence of shock in determining infection. He says: "The experiments on animals by Canalis and Morpurgo (*British Gynecological Journal*, 1899-1900), also by Tizzoni and Cattani, establish the above clinical observations, and in even mild forms of shock the subject is more susceptible to the infection that occurs during ordinary abdominal operations. Natural immunity to infection seems lessened or suspended, according to the degree of shock."

So, this comparatively bloodless method of Wyeth diminishes the danger of death, not simply directly, by saving the patient from death by hemorrhage, but indirectly as well, by minimizing shock and the consequent liability to infection.

Of course, it may be contended that the pins are entirely unnecessary, that tapes will do just as well to hold up the constrictor. This may seem proved by such a case as that of Deaver, where he abandoned the pins and successfully held the tube in place by tapes. I believe this might be done, but we have all had experience with the unsteadiness of an assistant's hand, and have seen it fail at a critical moment. With a thoroughly reliable assistant this naturally would never happen, but such aid is not always at hand when an operation is imperatively demanded. Then, too, where the pins have been shown to accomplish the purpose so admirably, it is incumbent on those who object to them to show that these objections are of consequence. I have seen no real objection to them in any of my three cases, unless the difficulty of disarticulating when the outer pin is placed too low be urged as one. But this would be unfair to the method, since the objection only obtains when the method is not properly carried out. When the outer pin is placed high enough and the disarticulation is done without sawing the bone, using it as a lever, the amount of blood lost is so small as to justify the application to the method of the term "bloodless," which Wyeth has given it. I have been so impressed by the reliability of the method for the control of hemorrhage that I shall continue to employ it in my future operations.

Ever since Wyeth read his paper before the American Medical Association in 1890, the method has steadily grown in favor. It has the endorsement of the best late works on surgery, both Bryant and the International Text-Book, giving it the preference over other methods. I believe the International Text-Book states the case fairly when it says of Wyeth's Bloodless Method:

"This operation is, without doubt, the simplest, safest and best method we have for hip-joint amputation."

The mortality from hip-joint amputation has been enormously reduced by this method until at the present time it has been brought down to the level almost of amputations in continuity of the thigh. The originator of the method, Dr. Wyeth, is now collecting all the cases and will publish his article within the next few months. The cases will be seen to have multiplied since his last report, and the mortality much reduced. The plan is so simple as to be within the reach of all, and can be carried out in the most unexpected emergency, since ordinary mattress needles or shawl pins, knitting needles even may be substituted for the Wyeth pins and ordinary twine, if needs be, for the elastic tube. No lack of preparation need afford any excuse for declining the operation.

Clinical Lectures.

Specially Reported for the JOURNAL from the Philadelphia Clinics.

I.

TYPHOID FEVER—TREATMENT.*

DR. F. P. HENRY.

This little girl is 12 years old, and was admitted February 12. As a child she was not very strong, and she had measles and diphtheria. For one week before admission here she was weak and feverish, but had no headache nor epistaxis until one day before. On admission her pulse was 132 and her temperature 101.2 deg.; she was listless and apathetic, had a weak, rapid heart; there were no spots; no enlargement of the spleen; no

*From Lecture at Woman's Hospital.

tympanites nor abdominal tenderness. Nevertheless she was treated on the supposition that this was typhoid fever, which supposition later proved to be right. The urine gave the diazo-reaction, which is obtained in the vast majority of cases of typhoid fever, but unfortunately also found in a disease which most resembles typhoid, acute miliary tuberculosis. Still in absence of all suspicion of tuberculosis, the diazo-reaction is very valuable. The Widal test gave positive results.

Her temperature has been between 101.2 and 104.6 deg., on one occasion lately going up as high as 105 deg., which was two days ago. Her pulse has been ranging from 130 to 110, a slow pulse compared with the amount of fever when you consider the age of the child. A child of this age would have, in all probability, a pulse of 120-140.

She has had but one tubbing, after which she was quite exhausted, and the bathing then we limited to sponging. There has been diarrhea to a decided amount. On the 8th there were five movements; on the 9th, four; on the 10th, there was one, and on this day she had a chill for twenty minutes. She was rubbed, was given stimulants, and external heat, and the chill subsided. After sponging, the temperature, which had risen, fell to 103 deg. So that this chill was not one to excite great alarm.

If it had been indicative of hemorrhage the temperature would have fallen considerably. Nor could this be indicative of perforation either. So that, if the patient has a chill it may be a source of alarm or not, according to the degree of fever. Again, chills are sometimes induced by the drug employed, specially by antipyrin, which I formerly used in typhoid fever and now do not. We may have abandoned thus a useful drug. I think myself that antipyrin has its uses. Strumpel recommended it used as an antipyretic in typhoid, 15 to 30 grains. I once saw a patient about the age of this one when the question arose whether or not antipyrin should be used. The child could not be tubbed and its physician was anxious to try the drug, and as it had been so recommended, I did not see why he should not use it. The child was given 5 grains of acetanilid, and the doctor thought the patient would die, for it went apparently into a state of collapse. It recovered from the disease, ut nearly succumbed to the treatment.

This little girl has had about three movements a day. I myself think diarrhea the better sign, though there are those who think constipation is better. Curds in the stools showed that she was getting more milk than she could digest.

On February 11, rose spots appeared and the spleen was enlarged; there was some tympany of the abdomen. The first sound of the heart was weak, which is regarded by some as an indication for alcoholic stimulants. There was no pulmonary involvement. On the twelfth she had three large stools, and was sponged. The ice coil has been kept applied to the abdomen, and calomel, grain 1-6, and bicarbonate of sodium, grains 2, given on alternate days. Now calomel at the beginning of an attack of typhoid was recommended many years ago by one of the great writers on the disease, Liebermeister, and it has been proved by large statistics that those cases treated at the beginning by full doses were better off than those who were not. It is a practice I have been following ever since its recommendation, and even if the patient comes to you during the second week you can give it, provided there is not profuse diarrhea. Nothing is said in the text-books about intestinal antiseptics. I am glad they are being given here—guaiacol carbonate, thymol, eucalyptol and olive oil. She has had brandy every four hours. Of nourishment, she has a quart of milk every twenty-four hours, broth once daily and albumin water once daily. The temperature on no occasion has reached the normal point. You recollect she was sick for one week before coming to the hospital, and the time is come now when we would look for a gradual improvement by lysis. Cases do not always run their typical course. The child is comfortable now, she is not delirious, has no diarrhea, no earache, and there is no reason why the temperature should not subside.

The period of illness is rather hard to decide. I think I remember the case of a young man who went to a dinner the day before he took to bed. He had not felt very comfortable, so he had taken a long ride on horseback until he and his horse were both exhausted. The next day he took to bed and that was the beginning of his illness. There it began rather suddenly and explosively.

She has several spots, the tongue is comparatively clean, there is no sordes, and of course no herpes. If you do see a

herpetic eruption you may conclude that you have something else to deal with than typhoid fever. It is important to keep the mouth and throat attended to in typhoid. One of the complications to be dreaded is suppurative otitis media, which always goes on to perforation of the membrane, and sometimes to the mastoid, and this may be prevented to a certain extent by keeping the mouth clean with a solution of borax or something of the kind. Dobell's solution is not usually objected to. Boric acid, five or ten grains to the ounce, and a little tincture of myrrh makes a good wash.

The typical course of typhoid is three weeks, and it has been divided into the three stages. Some authority has recommended that when the duration is four weeks, we call the last "amphibolus" stage. This case looks to me as if it were already somewhat protracted. The prognosis in children is good, much better than in adults.

The later statistics are remarkably uniform, that in hospitals where the cold tubbing is carried out in all its rigidity the mortality is between seven and eight per cent. Here the tubbing was stopped after she showed signs of exhaustion from the treatment. If the temperature continued high here an occasional bath of 95 deg., reducing it to 80 deg., might be very soothing.

There is one more thing here significant in diagnosis, a blood test, the number of leucocytes in a cubic millimeter. It is diminished here, and there will be no leucocytosis unless some inflammatory complication arises.

The mortality used to be 15 or 20 per cent. before the days of cold bathing. It is apparently a barbarous practice. Some of them fight against it, yet it is, I think, the thing to do. Some think that relapses are more common after tubbing, but more cases recover, and, therefore, there are more cases to have relapses.

To come back to the condition of the blood, the hypoleucocytosis differentiates this from some other diseases. When inflammation intervenes there will be hyperleucocytosis. Sometimes it is protracted because of suppuration in an organ, as a lymph gland, and we may suspect something like that if there is hyperleucocytosis.

Of course, it is useless to speculate on the source of infection. It is sufficient to say that she is a resident of Philadelphia.

II.

MITRAL STENOSIS AND CHLOROSIS.*

By DR. F. P. HENRY.

You recollect that this is the young girl in whose blood we found such a curious increase in the eosinophile cells, which is seen, you remember, in some cutaneous disorders, but rarely in chlorosis. On one occasion the percentage reached sixty-nine. On November 27 it was down to 11 per cent. It may be that this condition is more common than we suppose. At the last examination, when the red blood cells were almost normal, no eosinophiles were seen. The valvular murmur which she had did not disappear and never will. She came in again on the 6th, and it is very interesting to trace these cases. She complains of shortness of breath on going out into the fresh air and she has had a cough which is aggravated by the fresh air. Her bowels are constipated and sleep is poor. There is no albumin in the urine, and the color is not high as it usually is in valvular heart disease.

She is taking digitalis, five minims every four hours and strychnin every four hours; peptomangan three times a day in milk. She is improving, she sleeps better, sits up a little, and the appetite is better. Temperature is normal and pulse 82. It seems to me there ought to be some place for such people. Of course there are homes for incurables, and when we think of an "incurable," we picture to ourselves some who is crippled or paralyzed or something like that. There is no question that some people with heart disease are incurables and should be admitted as such. But there ought to be some halfway house where these people could be admitted till they could go out again. It is utterly impossible for a person like this to be cared for in her own home—to keep from working. Of course she can be kept here till she is better, then go home and infallibly relapse. There ought to be some place in the world where she could be cared for.

In the mean time she presents a typical case of mitral stenosis, and regurgitation also. The presystolic murmur is the more prominent of the two. You would know at once it was mitral stenosis from the low pitched rumbling sound. I should say there was a high degree of chlorosis, from the degree of pallor

* Lecture at Woman's Hospital.

the girl has. Her heart trouble dates from an attack of scarlet fever. Just why there is such profound anemia it would be hard to say. It may be there are the two separate affections; there is no apparent reason why the initial stenosis should give rise to such anemia. The blood corpuscles number about 3,500,000 and the hemoglobin is only 35 per cent. The indication is for iron and she is getting it in the organic preparation of peptomangan which is widely employed now.

Above all, rest will improve her. The constipation of course must be looked after on account of the chlorosis. Predictions of a relapse are natural though we are always surprised when it comes true.

Charity Hospital Notes.

Specially reported for the JOURNAL.

CONSTRUCTION OF PLASTIC NOSE AFTER A SYPHILITIC DESTRUCTIVE PROCESS.

BY E. DENEGRE MARTIN, M. D., PROFESSOR ON MINOR AND CLINICAL SURGERY IN THE NEW ORLEANS POLYCLINIC.

Patient is a negress, aet. 25. When she was first seen by Dr. Dyer in the female outdoor department, a mass of fungating, verrucose papillomata presented, which had some semblance to the original nose, the size of which the mass approximated. Here and there were deep furrows which pedunculated some parts of the tumors. Altogether the area involved the region of the nose, the alæ nasi, a part of the upper lip and cheek. There was a tendency to a retrograde process, evidenced by ulceration at the borders of the mass. The top and surfaces were covered with many crusts, leaving ulcerations beneath, when removed. Antisyphilitic treatment was prescribed as follows:

Hydrarg. biniodid	gr. v.
Sodii iodid	℥ss.
Syr. et aquæ	℥vi.

Sig:—Teaspoonful three times a day.

This rapidly caused absorption at the base of the process,

which resulted in a general sloughing of the verrucose growth. At the end of one month the surface presented an irregular scar, which is well shown in figure I. Dr. Dyer agreed with Dr. Martin upon the advisability of attempting a graft.

In proceeding to construct a plastic nose upon this site, we began by dissecting away the extensive scar tissue from the lines where the edges of the flap were to fall. The Indian method was adopted. The removal of scar tissue having been completed, a piece of oiled silk was used to mark out the size and shape of the flap to be used, the flap being cut one-half an inch too long, the excess in length being thinned for turning under on either side of the columnæ to improve appearance and prevent contraction of the nostrils as cicatrization took place. Owing to the want of necessary material, Kugan's suggestion of turning down the skin over the nasal bones could not be adopted. The suggestion is a good one, though, and should be followed when possible. A silver bridge, shaped like a cross, was bent so as to give support and elevation to the flap and placed in position. When the flap had been dissected up from the forehead, the excessive length was thinned and turned under on either side of the columnæ and so sutured. The flap was then dropped over the bridge and sutured in place. Drainage tubes were inserted into the nostrils—serving the double purpose of affording drainage and giving shape to the nostrils as healing progressed. The wound occasioned by removal of the flap from the forehead was partially closed on the left by bringing a flap one-half an inch in width and two inches in length from above and suturing to the pedicle, the remaining portion of the wound being covered with the Thiersch graft. The wound healed primarily at all points, except in the region of the alæ nasi on either side, where some suppuration took place, but readily yielded to treatment. Considering that strict asepsis could not be maintained throughout the operation, this was to be expected.

At the expiration of fourteen days the projection formed by the twisting of the pedicle of the flap was dissected out and the nose completed. The silver bridge proved quite useless, and at this latter sitting it was removed—a larger one being inserted instead, which also proved a failure, and had to be removed. The opening in the face continued to contract to such an extent

it was found necessary to cut through the columnæ and dilate. This contraction was the action of the old cicatrix on the site of operation, and not a sequence of the operation—in fact, contraction seemed to be to some extent prevented by removal of scar tissue to insure healing. Thirty-three days after the original operation a silver probe, sharpened at one end, was passed through the lower segment of the plastic nose, cut off and left buried, after having been bent with convexity forward. This step was taken to prevent collapse of the flap on inspiration, and improve appearance. At the present the opening has still to be dilated occasionally, as cicatrization progresses, to prevent constriction of the orifice.

The photo cuts herewith show the successful result of operation:

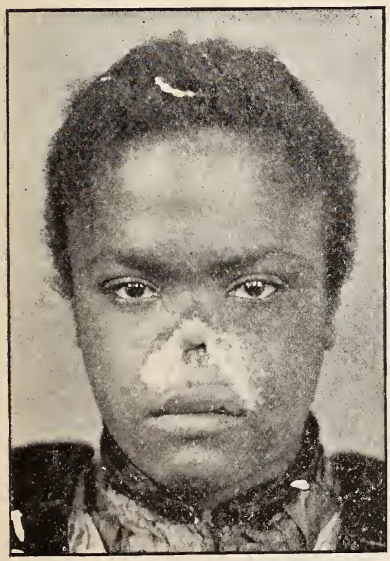


Fig. 1.



Fig. 2.

These cuts show well the extensive scar tissue—beginning to contract on the right side, and drawing up the lip.



Fig 3.

Figs. 3 and 4 show completed nose. Scar tissue on right continued to contract — though slightly benefited by operation. Surface of scar on forehead is made more conspicuous on account of manner in which light fell on subject when photograph was taken.



Fig. 4.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE PREVENTION OF PREMATURE BURIAL.

It is natural that people should dread being buried alive and with many the fear is even excessive. While premature burial must be an exceedingly rare occurrence and scarcely to be thought of except during the prevalence of epidemic diseases, and particularly of such as are accompanied by collapse, yet it is wise to leave nothing undone which can prevent the most remote possibility of such a horrible thing.

The "American Society for the Prevention of Premature Burial" is applying for a charter in New York. Their purpose is to have laws enacted to accomplish such prevention, and they propose to compel physicians to make certain tests before giving certificates of death.

All this is scarcely necessary under ordinary circumstances, for some observation on the part of the physician, coupled with the fact that bodies are kept twenty-four hours or more, would be a sufficient safeguard.

In many parts of Europe a medical official is commissioned for each district, municipality, or department, whose function is to establish that death has actually occurred. If that example is not followed through a disinclination to create additional public functionaries, it could easily be insisted upon that physicians actually see and examine a corpse before issuing a certificate of death in the case. It is notorious that such a precaution is not generally taken, and we know of more than one occasion in this city upon which a death certificate was given for an individual who turned out not to have been yet dead at the time such certificate was issued. Of course this should not be possible,

and a certificate of death, like any other certificate, should be given only as a result of the writer's own knowledge.

This matter might well be taken up by medical societies. A rule adopted by the medical profession to the effect that no certificate should ever be given before not only viewing, but examining the supposed corpse, would go far towards relieving the apprehensions of the public in regard to premature burial.

HEALTHFUL NEW ORLEANS.

A glance at our mortuary report for August is convincing as to the satisfactory health condition of New Orleans during that month, and we understand that, up to the date of writing, September promises to be correspondingly good.

There were four hundred and thirty-five deaths during the month and, of these, thirty were from injuries and not disease.

The death-rate per thousand, per annum, for the month was only 14 for the whites and 17.40 for both white and colored. The total mortality from fevers, including all types of malarial and typhoid, was only twenty for the whole month. The above figures are more eloquent than any dissertation could possibly be, and we simply desire to submit them without argument.

GALVESTON!

The dreadful disaster at the Island City last month has been so completly described in the daily papers that it is only left for us to express our deepest sympathy for Galveston and Texas; also our heartfelt wishes for the quick recuperation of the devastated city.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

Some Methods of Preventing Shock and Infection.—In a a paper prepared for the Thirteenth International Medical Congress, and published in the *New York Medical Record* of August 11, 1900, Fenton B. Turck, of Chicago, makes what we believe will prove valuable suggestions to the operating surgeon. As the result of a large number of experiments on animals and a considerable experience with the methods suggested in operations upon the human being, he draws the following conclusions:

I. Pathogenic and non-pathogenic bacteria found on and in the skin before and during surgical operations, may produce infection.

II. The skin, especially in abdominal operations, is a source of infection that may cause death, though all usual precautions are particularly taken. Susceptibility to infection is produced in cases of lowered vitality and weakened condition, or in cases in which shock is present, from whatever cause, in a mild or severe form.

III. The present methods in use, of towels and laparotomy sheets, do not sufficiently protect the field of operation.

IV. The use of the rubber protector, which is made to fit close to the skin, more thoroughly prevents the danger of infection from the skin, and also lessens the liability of the skin becoming contaminated from the escape of visceral contents, pus, or other infected material occurring during the operation.

V. The peritoneum may become infected from the escape of visceral contents or from any infected cavity open during surgical operations in the abdomen. Infection may result even after the most careful precautions are taken, notwithstanding the use of gauze and careful packing now in common use.

VI. When death occurs from supposed "shock" or "exhaus-

tion," especially when the viscera have been exposed to dangers of infection by the escape of visceral contents, the death is probably due more to the infection than "shock" or "exhaustion."

VII. Whenever practicable, the viscera may be drawn through the small openings of the protective rubber shield overlapping the abdominal wound, as described in this paper, and absolute protection to the abdominal cavity is secured.

VIII. Exposed viscera may be covered with a rubber hood kept warm by small rubber hot water bags, thus preventing contamination as well as lessening susceptibility to infection.

IX. Animals naturally immune to certain bacteria are rendered susceptible by exposure to air for one hour or more.

X. Susceptibility can also be produced in an animal naturally immune, by long manipulation of the abdominal viscera, notwithstanding all ordinary precautions are taken. Visible trauma is not essential.

XI. In animals in which susceptibility is not artificially produced, only slight effects are observed after intraperitoneal inoculations of micro-organisms taken from the skin before surgical operations.

XII. When an animal is rendered susceptible by exposure of the viscera to air, pathogenic and many non-pathogenic micro-organisms inoculated may cause infection followed by death.

XIII. Subcutaneous or intravenous infusion of physiologic salt solution does not materially render the animal less susceptible after the exposure and manipulation of the viscera.

XIV. When heat at 48 deg. or 50 deg. C. is applied within the abdominal cavity during the time corresponding to the exposure and manipulation of the viscera (about one hour) inoculation by pathogenic or non-pathogenic germs seldom results in infection and death.

XV. If infection does occur, death is delayed or seems prevented, as a result of the procedure described. Susceptibility to infection is not materially decreased by the external application of heat.

XVI. Hot water bags placed in the abdominal cavity during an operation prevent shock or collapse, and also produce a modified immunity or lessen the susceptibility to infection.

XVII. In severe operations, when extreme shock or collapse is present, resuscitation is best accomplished by the application

of heat within the stomach and abdominal cavity by the methods already described.

The Real Value of Digitalin and Other Derivatives of Digitalis in Their Bearing Upon the Treatment of Surgical Shock.—All who have witnessed in the course of prolonged operations the gradual failure of the heart's action have felt the need of a reliable stimulant to that action, freely soluble and unirritating, prompt in its effect and easily gauged in its dosage. The value of strychnin is well recognized, and the life-saving power of digitalis has been too often practically shown to be doubted. When combined with nitroglycerin, to overcome the effect of digitalis upon the arterioles, this heart-invigorating action of digitalis is so much enhanced that no surgeon is justified in undertaking an operation likely to give rise to shock without having these valuable agents at hand. Substitutes are, of course, to be had, but these three agents, namely, strychnia, digitalis and nitroglycerin, are the *ne plus ultra* of surgical desiderata for the management of shock, so far as drugs are concerned. It is therefore of the highest importance that all three of these drugs shall be obtainable in their most effective forms. The salts of strychnia and the therapeutic forms of nitroglycerin are convenient and reliable, but the preparations of digitalis are so variable, and therefore so uncertain in effect and their administration by hypodermatic injection is, in some respects, so objectionable, that the surgeon demands something of equivalent value in a form that shall prove reliable and non-irritating. Naturally, the search has been to obtain from digitalis itself some substance which will fill all the requirements of a heart stimulant. A recent article contributed to the August number of the *American Journal of the Medical Sciences* by Arnold and Horatio C. Wood, Jr., is of great value in this connection. They thus explain the impetus to these investigations: "The conflicting results obtained by the investigators of the derivatives of digitalis, the differences of opinion which exist among clinicians as to their therapeutic value, and the importance of determining whether any of them represent the activity of digitalis have led the writers to undertake this research."

After enumerating the constituents supposed to have been isolated from digitalis and calling attention to the varying re-

sults of different investigators with these substances, depending largely upon the confusion existing as to the identification itself of the substances experimented with, the writers proceed to determine the effects of products known to be uniform and stable in composition. The substances employed in these investigations were digitalinum germanicum and the digitoxin furnished by Merck and the U. S. P. tincture of digitalis.

The conclusions drawn from this valuable research are as follows:

1. Digitalin and digitoxin each represent the full circulatory powers of digitalis.

2. Digitalis, digitalin and digitoxin stimulate the cardio-inhibitory mechanism both centrally and peripherally. In larger doses they paralyze the intrinsic cardio-inhibitory apparatus.

3. They all cause a rise of blood pressure by stimulating the heart and constricting the blood vessels.

4. Very large doses paralyze the heart muscle of the mammal, the organ stopping in diastole.

5. Digitalin of Merck is a stable compound, one gram of it being equivalent to about 70 c. c. of tincture of digitalis.

6. Digitoxin is not to be recommended for human medication on account of its irritant action, which makes it liable to upset the stomach when given by the mouth, or to cause abscesses when given hypodermatically, and on account of its insolubility, which renders it slowly absorbed and irregularly eliminated, having a marked tendency to cumulative action.

As to dosage the writers make some interesting and practical observations. After showing that digitalin and digitoxin are circulatory stimulants of considerable power, "resembling closely, if not identical with, digitalis tincture in their pharmacologic activities," they remark: "Nevertheless, neither of them has achieved such clinical results as to gain the full confidence of the profession, the general verdict being that digitalin is uncertain in its action."

"It is hard to see why an active principle representing, as this one seems to, the full therapeutic value of a drug, should be less uniform in its results than the cruder preparation. And it is to our minds equally as impossible that a substance should affect so powerfully and certainly the circulatory system of a dog and not that of man. In this connection it may be

remembered that some years ago the tincture of digitalis was dubbed uncertain, but since we have learned to give it in equivalent dose it has proven itself equal to the infusion in efficiency. We think the same mistake concerning digitalin is hindering the profession from the use of a valuable remedy." "Several years ago Dr. Beates (*Journal of the American Medical Association*, 1897, XXVIII, 1209) quite startled some of the more conservative practitioners of medicine by advising them to give digitalin in half grain doses, and telling of excellent results achieved in this way. Dr. Beates' doses agree so closely with those we have arrived at by reasoning from our experiments that it seems surprising that no one else has before this confirmed his statements."

We are sure these conclusions will strike our readers as of the utmost importance and we are glad to bring them before the profession for earnest consideration. Dr. Warren Stone, Sr. was an eminently practical doctor and had an abundant fund of what Prof. Chaillé calls "educated common sense," and we have often heard it remarked that he was in the habit of giving from one to four teaspoonfuls of tincture of digitalis without bad, but with really good, result. We believe this, too, was often the practice of the late Professor Richardson. Should we not then refuse to give up such an evidently valuable drug, but rather revise our *dosage* of digitalin, with the reasonable expectation, in the light of these researches of Arnold and Wood, of greater satisfaction to ourselves and more benefit to our patients? We hope sincerely these conclusions will be soon fully confirmed both experimentally and clinically. Then will a new impetus be given to our efforts in the saving of life threatened by shock.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Report of the Thirteenth International Congress of Medicine, Paris, August 2-9, 1900.—*Section on Therapeutics, Pharmacology and Materia Medica.* Prof. Naunyn

of Strasburg read a paper on the treatment of cholelithiasis. After briefly reviewing the morbid process the speaker concluded that the chief therapeutic action aimed at preventing obstruction of the biliary passages and curing the infectious complications (cholecystitis, cholangitis). The cholagogues are indicated, but it is questionable whether their action is perfect when the inflammation of the biliary mucosa and the obstruction of the passages exist.

Drs. A. Gilbert and L. Fournier of Paris, speaking on the same subject give rules for the prophylaxis: Regular meals at short intervals, clothing exerting no pressure on abdominal organs, outdoor exercise, care of digestion. With these hygienic precautions should be associated the use of alkalines, cholagogues, massage of the abdomen and of the gall-bladder in particular, cold water enemata in large quantity. As regards the solvent action on gall-stones, hydro-mineral treatment (spas) is certainly efficient. Operative measures are indicated in complicated cases. Results are encouraging.

Professor Hayem, of Paris, read a paper on Indications of Venesection. The speaker made a few general remarks and enumerated the following conditions in which bloodletting is distinctly indicated: Pulmonary edema, edematous forms or simply congestive forms of pneumonia. Cardio-vascular disturbances with high blood pressure chiefly, but also in asystole, congestive and hemorrhagic forms of acute nephritis, cerebral congestion and beginning cerebral hemorrhage with high blood-pressure, acute or recent uremia, puerperal convulsions, poisoning by carbon oxide.

In all other diseased conditions blood letting is questionable, chiefly so in chlorosis.

Dr. R. Lépine, of Lyon, read a paper on the question: "Should we treat Fever?" The speaker said that from ancient times up to the present century fever was dogmatically looked upon as possessing a salutary virtue. Liebermeister pursued fever like an enemy and thought he treated it in combating hyperthermia. But closer study proves that if hyperthermia indicates, in general, the gravity of the febrile diseases, it is not by far the chief factor. The real object is to treat the fever specifically. In some maladies such a happy result has been made possible, but in others we can only watch the reaction of the organism, at

times moderating it by means of antipyretics, which act somewhat specifically for a number of pyrexias, at times stimulating it by means of hydrotherapy, at times seeking refrigeration chiefly in marked hyperthermia, finally in sustaining the economy. Disease is complex, and the object of therapeutics proper is to investigate and combat the infinite perplexity of its elements.

Sir Lauder Brunton, M. D., etc., read a paper on the Physiologic and Therapeutic actions of Digitalis and of its active principles. The speaker spoke in detail of the action on the heart, the blood-vessels and secretion of urine. As to the active principles they all have an action similar in kind but differing in degree. In cases of aortic regurgitation digitalis is unnecessary and not without danger when compensation is complete, very useful when compensation fails. When the blood-pressure is already high digitalis may be injurious by increasing it still farther and thus causing symptoms of angina pectoris or tending to produce apoplexy.

Dr. A. Joanin of Paris read a paper on Digitalis and its Active Principles. The speaker says that failure in obtaining constantly at the bedside the effects of digitalis is due to fraud and substitution of the material and various preparations on the market. He proposes to control the market by testing the botanical value, chemical property and clinical action of the leaves, principles and preparations of digitalis. He asks that a uniform terminology and standard for extracting principles as well as for making preparations of digitalis be adopted by all pharmacopeias, thus making a step towards the creation of an International Pharmacopeia:

Organotherapy in China.—Dr. Bouffard, in the *Annales de Médecine Coloniales* publishes about Chinese medicine some curious notes which he gathered at Tchen-Tou, capital of the province of Set-Chouen, China. The following information refers to organotherapy, which apparently was known to the Chinese physicians since a very long time:

The juice of macerated pork lungs is administered with good results in pulmonary diseases. Pork bowels are ordered by the native physicians ingested in cases of dysentery, chronic diarrhea, and in all intestinal diseases. Brain is ordered in all

cases of headache when the pain seems to originate from within the cranium. The same rule is followed in mostly all diseases. As the Chinese practitioners are not familiar with the hypodermatic method, ingestion is the only mode of their administering organic remedies, and as a result of their utter ignorance of human anatomy they know absolutely nothing of the existence of many organs. This explains how the ovary, the thyroid gland, for example, are never used in their treatment. The sperm might be considered as a powerful tonic, since it forms the active principle of pills used in chlorosis, anemia, convalescence of severe cases. It has been ascertained from personal inquiry that some pharmacists hired at great cost a number of young men 20 to 25 years old, who were to supply them with the product of their testicular secretion. The sperm thus obtained was collected, dessicated, made into pills and put on sale.

The Chinese treat wounds by sprinkling urine over them. This is a wide spread practice in the Far Orient. It is therefore not a custom peculiar to some of our occidental country folks. Taken internally, urine, says the Chinese Æsculapius, stimulates circulation of the blood. It is valued as a most active oxytocic (accelerating labor.) The parturient woman, for that purpose, should drink the urine of a male child 4 to 5 years old, and that part of it voided in the middle of micturition, so the child urinating in three vessels, the woman drinks the contents of the second.

For a woman suffering from chlorosis, no remedy is valued more than her own placenta after delivery, provided she was at her term and had a normal labor. It is ordered ingested in its natural state or in pills after dessication.

One may judge from this summary enumeration to what bold degree organo-therapy seems to be pushed in China.—*Journal de Médecine et de Chirurgie Pratiques*, July 25, 1900.

On the Passage of Alcohol, Ingested by the Mother, to the Fetus.—Experiments upon pregnant guinea-pigs, to whom alcohol was given by means of the stomach tube, proved that the alcohol appeared both in the blood of the mother and of the fetus.

Parturient women were given a dose corresponding to one-half of a cubic centimeter of absolute alcohol to the kilogram

body weight, one hour before the birth of the child. Examination of the blood obtained from the placental end of the cord showed that alcohol was present.

Experiments made with the milk of dogs proved that alcohol appears rapidly after its ingestion, being found in fifteen minutes, and reaching its height in three-quarters to one hour. With human milk the results were similar.—*Gazette des Maladies Infantiles, Vol. II, No. 1, Archives of Pediatrics*, August, 1900.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Diuretics by the Rectum.—In *La Semaine Médicale* of January 11, 1900, the statement is made that in certain cases of cardiac and renal dropsy where it is deemed inadvisable to administer diuretics by the mouth, we may with advantage give the double salt of theobromin and sodium salicylate by the rectum. It will be remembered that the sodium salicylate of theobromin is sometime called diuretin. It may be injected in starch water into the rectum in cases of cardiac and renal dropsy in a dose of from 30 to 45 grains, and it is asserted that this method of treatment will often result in profuse diuresis. As diuretin is not readily soluble in cold water it must be dissolved in hot water and given at once, care being taken that the water is not sufficiently hot to burn the bowels. If on the other hand the water is allowed to become thoroughly cold the preparation will be precipitated out of its solution.—*The Therapeutic Gazette.*

For Amenorrhea.—The *Gazette Hebdomadaire de Médecine et de Chirurgie*, of April 1, 1900 (*New York Medical Journal*, May 5, 1900), attributes the following to M. H. C. Bloom:

℞ Sulphate of strychnin ..... 1 and 4-5 grs.
Oxalic acid ..... 9 grs.
Peptonate of iron
Lactate of manganese, of each..... 120 grs.
Compound extract of colocynth..... 30 grs.

M Divide into sixty powders. One powder to be taken about an hour after each principal meal.

Management of the Hair During and After Fevers.—Jackson (*New York Medical Journal, The Therapeutic Gazette*) gives the following directions in regard to the care of the hair after fevers:

Once or twice a week a little pomade containing a drachm of precipitated sulphur to the ounce of cold cream, should be well worked into the scalp, or a three per cent. lotion of resorcin in oil and alcohol may be used daily. Many prefer a liquid preparation. Once in two or three weeks the hair and scalp are to be washed. For the shampoo, any good soap may be used, though the most convenient kind is a liquid one, such as the tincture of green soap. If the latter is used, the patient should be directed to invert the bottle on a piece of flannel, dip the flannel in warm water and use just as little soap as will make a good lather. So used, the soap will not convert the hair into a mass of strings. If too much soap is used it will be difficult to wash it out. After washing, the hair is to be carefully dried, and a little of the pomade rubbed into the scalp to take the place of the natural oil removed in the washing.

Petrosulfol in the Treatment of Skin Diseases. — Ehrmann (*Wiener Klinische Rundschau, The Therapeutic Gazette*) has used petrosulfol in 500 cases of skin disease and with excellent results. This drug is not unlike ichthyol, being a bituminous preparation which contains sulphur. It can be incorporated in ointments, or can be used in watery solution. The formula used in eczema is as follows:

℞ Petrosulfol 400
Unguent casein 20.00-40.00

Or,

℞ Petrosulfol 6.00
Lanolin .....
Vaselin, àà 20.00
Oxid. Zinci .....
Amyli (or talci venti), àà 10.00

These ointments do not permanently stain the clothing.

Ehrmann states that petrosulfol is an especially valuable medicament in the treatment of papilloma or squamous and acute or chronic eczema, pustular eczema, and inflammations of the skin, especially ecthyma, furunculosis, and sycosis. The drug is also useful in curing hyperemia, such as the result of frost-bite, and in the swelling of the hands and feet. It inhibits not only

staphylocci, but also the streptococci of erysipelas. It is further useful in the treatment of suppuration following gonorrhea. In not a single case did it cause symptoms of irritation, excepting in patients who react even to applications of vaselin. It is moderate in cost, and no patient seemed to exhibit towards it an idiosyncrasy. In chilblains the drug was used in the form of a five or ten per cent. petrosulfol collodion. Erysipelas was treated by a solution of petrosulfol, which showed itself as potent as ichthyol in the management of this disease. As a dusting powder for the treatment of sweaty hands and feet the following preparation is used:

℞ Petrosulfol 5.00
Talci veneti 50.00
Amyli 100.00

Quinin Bichlorid in Cancer.—Cancer has been treated by Dr. Jaboulay, of Lyons, with daily hypodermic injections containing from one-half to one gram (8 to 15 grains) of quinin bichlorid, on the assumption that the probable cancer parasite belongs to the protozoa, to which quinin is an active poison. One case, afflicted with recurrent carcinoma of the right breast, extensive involvement of the neighboring gland, and a badly swollen arm, began to improve by the end of a week and, at the end of twenty days the swelling of the arm had entirely subsided, only two or three movable glands could be felt, and the tumor of the breast had shrunken to one-quarter of its previous size. Another woman, with a cancer of the uterus which had perforated the bladder, was relieved by the third day and was able, for the first time in six months, to enjoy a night's sleep. The third case was a cancer of the breast with involvement of the axillary gland and signs of a secondary tumor at the base of the brain. After a dozen injections the brain symptoms had disappeared completely and the primary tumor had diminished a third.—*Merck's Archives.*

Cholera Infantum:

℞ Salol ..... 3 grn.
Pepsin .....
Pancreatin ..... of each 2½ grn.
Bismuth Subnitrate ..... 3 grn.
Extract Nux Vomica ..... ½ grn.
Sodium Bicarbonate ..... 6 grn.
Powdered Ginger ..... 1½ grn.

Make twelve powders and give one every two hours, alternating with 30 grn. of chalk mixture.

—*Buffalo Med. Jour—Merck's Archives.*

SUNSTROKE:

℞ Spirit Glonoin..... 2 drops.
Water..... 1 fl. oz.

Teaspoonful every quarter of an hour till symptoms disappear. Apply arnica compresses to the head.

—*Riforma Medica—Merck's Archives.*

Department of Ear, Nose and Throat.

In charge of DR. A. W. DEROALDES and DR. GORDON KING, New Orleans.

[Resumé of subjects discussed in the Section of Laryngology and Rhinology at the Thirteenth International Congress of Medicine, Paris, August 2, 1900.]

THE ANATOMO-PATHOLOGIC DIAGNOSIS OF CANCER OF THE LARYNX.—*By Prof. V. Fraenkel, Berlin.*—For the diagnosis of tumors of the larynx the removal and examination under the microscope of a piece of the growth is of fundamental importance. A positive result alone, however, is conclusive as to the nature of the neoplasm and the course to be followed in the treatment. The difficulty often lies in the fact that the pieces removed are necessarily very small and do not permit a thorough examination. The author favors the method of coloring known as Van Gieson's, or staining with picrocarmin, after inclusion of the piece in paraffin and the cutting of thin sections.

It does not suffice for the diagnosis to find groups of epithelial cells, but it is necessary to see the epithelial outgrowths in parts where they should not be seen. If it is a question of penetration of the surface epithelium into the deeper structure, as occurs in a number of pathologic processes, like syphilis, the closest examination must be made before we can draw correct conclusions. The irregular structure of the epithelium is the characteristic symptom of cancer, as also the atypic epithelial cell formations.

DIAGNOSIS OF LARYNGEAL CANCER.—*By Prof. Moritz Schmidt.* —The symptoms of laryngeal cancer, such as heaviness, pain,

stenosis, odor, etc., are not the most characteristic and are to be found in several other diseases of the larynx, and the growth may spring from any part of the larynx. Cancer differs from other tumors of the larynx in that it preserves its original characteristics throughout the entire course of the disease, except in those cases where the growth begins in the deep tissues near the perichondrium.

Perichondritis may co-exist with cancer of the larynx and thus mask the pure symptoms. The cancerous growth of the ventricle of Morgagni resemble greatly perichondritis of the internal surface of the thyroid cartilage. The diagnosis is sometimes very difficult and may be confused with tuberculosis, syphilis, sarcoma, etc.

It is necessary to take into consideration the history of the affection, the search for possible co-existent or stimulating diseases, the effect of anti-syphilitic treatment, and the result of an examination of a piece of the tumor under the microscope.

Conclusions: 1st. Cancer of the larynx nearly always presents from beginning to end the character of a mixed tumor. 2nd. Cancer beginning in deep tissues gives rise sometimes to an outgrowth of papillomata upon the surface of the mucosa which gives it a great resemblance to perichondritis. 3rd. Cases of cancer arising from the ventricle of Morgagni present an image in the laryngoscope which resembles perichondritis very much. 4th. In rare cases the cancer commences behind, almost beneath, the cricoid cartilage, and only gives evidence of its presence in the beginning by a paralysis of the recurrent nerve; 5th. To exclude syphilis it is necessary to give three grams of potassium iodide in fifteen days. 6th. A certain diagnosis may be made by removal and examination of a piece of the growth. 7th. The only positive diagnosis is to be made with the microscope.

Purulent Ethmoiditis.—*By Dr. M. Hajek, Vienna.*—By purulent ethmoiditis is meant those diseases of the mucous membrane and of the osseous framework of ethmoidal bone accompanied by a purulent discharge, and does not include those rarer affections of the part due to tuberculosis, syphilis, neoplasms or traumatism. Of the disease confined to the mucous membrane there are three forms: the acute catarrhal form, involving either the nasal surface of the ethmoidal bone,

or the deeper cells of the labyrinth, which latter has a tendency to chronicity; chronic catarrhal inflammation, characterized by hypertrophic tumefaction of the muco-periosteal covering, either of the external surface or within the cells, and the formation of polypi on the nasal wall of the ethmoid; persistent form of chronic inflammation, which is recognized by an excessive formation of polypi on the nasal wall, the formation of erosions on the mucous lining of the cells and the production of granulation tissue.

The diseases affecting the osseous portion are divided into two classes: those producing superficial alterations of structure and those producing deep alterations. The former consists in an irritation of the periosteum and followed later by a condensing or rarifying osteitis; the latter form where the deeper structures are involved is associated with necrosis of the bone as occurs in virulent forms of acute ethmoiditis and in chronic ethmoiditis from pressure or from thrombo-phlebitis and periostitis of the opposite side. Then also necrosis of the ethmoid may occur from extension of an osteitis or periostitis originating in the maxilla or the orbit.

The Treatment of Purulent Ethmoiditis.—*By F. H. Bosworth, New York.*—In purulent ethmoiditis the essential condition is one of imprisoned pus. Each of the trabeculæ involved constitutes, as it were, a small abscess, there is but little tendency to a spontaneous cure. The prominent and practically only indication is to open each and every cell and to release the imprisoned pus accumulation. If this be true, the important consideration is as to the best method of accomplishing this end. We may use the gouge, snare, forceps, curette, scissors, burr, spoon or other devices. In my own experience the end is best accomplished by first uncapping the ethmoidal cells by the use of the wire snare écraseur, and then breaking down the trabecular walls by means of the burr.

The Indications for Thyrotomy.—*Sir Felix Semon, London.*—Thyrotomy is a rare operation, and until recently not popular. Has gained favor of late because of the improvement in technic, the lessening of danger and the better results obtained.

Where other methods, such as intra-laryngeal operations, in-

tubation, dilatation, etc., fail, thyrotomy is to be adopted in the following class of cases:

(1) Foreign bodies impacted in the larynx. It is dangerous to leave a foreign body which has become implanted in the larynx too long a time.

(2) Wounds of the larynx, such as is caused by fractures, fire-arms or attempts at suicide.

(3) Laryngocele, rarely indicated.

(4) Laryngeal stenosis. Sometimes, as for example in syphilitic thickening and stricture, thryotomy, followed by excision of the tumefied parts gives excellent results. However, it is impossible to guarantee the result, as there is a chance of the stenosis recurring.

(5) Acute perichondritis of the laryngeal cartilages. Rarely indicated but sometimes necessary for relief of the stenosis.

(6) Tuberculosis of the larynx. As indicated by Coris, the results are sometimes very satisfactory, but there is always danger of tuberculous infection of the wound.

(7) Sclerosis of the larynx. For this, thyrotomy is apparently the best method, but does not insure certain protection against a recurrence of the condition.

(8) Benign growths of the larynx. The intra-laryngeal method is preferable when it can be employed, but there are exceptions to the rule. It is necessary to recognize the special indications in each case. Thyrotomy is not a guarantee against a recurrence of multiple papillomata.

(9) Malignant growths of the larynx. The early removal of neoplasms when they are strictly limited to the interior of the larynx is at present the most important indication for thyrotomy. The advantage over the intra-laryngeal method for these cases is great.

The Technic of Thyrotomy—*By E. Schmiegelow, of Copenhagen.*—The operation, which should be preceded by tracheotomy, is done under profound narcosis.

The tracheal canula should be so made as to prevent the aspiration of blood during the operation. The Hahn tampon canula is the best.

After having opened the larynx by an incision through the thyroid cartilage, the lower part of the pharynx must be packed with a tampon to prevent entrance of saliva into the larynx.

To diminish the sensibility of the larynx, a solution of cocain should be applied to the mucous membrane.

The operation finished and the hemorrhage arrested, the tampon canula is removed and the anterior of the larynx powdered with iodoform. The wound is simply covered with iodoform gauze, which should be changed frequently during the first few days. The patient should lie with the head as near horizontal as possible, and after five or six days the wound will be sufficiently healed to permit of the patient's sitting up.

The Immediate and Final Results of Thyrotomy.—*By Dr. Goris, of Brussels.*—In 105 cases thyrotomy was performed for the following diseases: Sixty-two for malignant tumors of the larynx, fourteen for tuberculosis, twenty-five for benign tumors, two for stenosis, one for foreign body, one for rhinoscleroma. In these 105 cases four died of pneumonia within eight days after the operation.

Thyrotomy, considered by itself, enters into the category of benign operations as the mortality from the operation is less than 4 per cent.

Thyrotomy for Malignant Tumors.—Malignant tumors affect more often the male than the female sex. In these statistics, out of sixty-two cases fifty-five were males, three females, and in four cases the sex was not mentioned.

The proportion, according to age, was as follows:

Below 30 years	0
Below 40 years	4
Below 50 years	14
Between 50 and 60	20
Between 60 and 70	18
Between 70 and 75	4
Age not mentioned	2

As to the effect of the operation on the voice, the result depends upon the extent of the operation in the larynx. In general the removal of one vocal cord permits the emission of certain sounds, and in some cases the voice remains excellent after the removal of one cord as the result of the formation of a cicatricial band.

In recording the final results the sarcomata and carcinomata are considered together. Out of the sixty-two cases mentioned seven are withdrawn from the statistics, as in these cases the thyrotomy was followed by the more serious procedure of extir-

pation of the larynx. In addition six cases are of too recent date to consider the final result.

Of the forty-nine remaining cases one survived the operation more than ten years, eight cases survived for five to eight years, and fourteen for two to five years. This gives a proportion of 46.9 per cent. of what may be considered cures. In seven cases there was no recurrence within one year after the intervention.

Thyrotomy for Tuberculosis.—Here the results are much less brilliant. Out of fourteen cases three alone could be considered as cured. In the others the operation seemed to have accelerated the progress of the malady.

Thyrotomy for Benign Tumors, Stenosis, etc.—As regards the voice the results are variable; in general good.

For diffuse papilloma thyrotomy is most often performed and is the operation of choice.

In two cases operated for stenosis, one was cured; in the other normal respiration through the larynx was not restored.

In a case of rhinoscleroma of the larynx Chiari obtained a complete cure by excision of the sub-glottic tumefaction.

Miscellaneous.

The Treatment oe Delirium Tremens by an Injection of Artificial Serum.—*La Presse Médicale* of January 24, 1900, contains an article by Masbrenier upon this subject. Believing that the nervous symptoms result from chronic intoxication with alcohol, and that there are present in the body poisonous materials which produce the symptoms, this author uses salt solution, injected under the skin in the same manner as it is commonly employed in combating various forms of toxemia. The method is, of course, directly antagonistic to the so-called sedative methods by the administration of opium. This author claims to have obtained excellent results in the few cases in which he has instituted this method. If it is possible to avoid sedatives, such as chloral, opium, bromide and similar substances, by the institution of this treatment, a distinct gain in its therapeutics will have been made.—*The Therapeutic Gazette.*

Medical News Items.

Absentees among the profession are returning and look more or less invigorated by their vacation. Now for the patients!

The Mississippi Valley Medical Association will meet in Asheville, N. C., on October 9, 10 and 11, 1900. Many papers have been announced and ample entertainment is offered, including a smoker, a banquet, a ball and an excursion.

The Southern Surgical and Gynecological Association will meet in Atlanta, November the 13th, 14th and 15th, under the Presidency of Dr. A. M. Cartledge, of Louisville. Prospects are said to be splendid for a successful session. Members of the profession are cordially invited.

The Ouachita Parish Board of Health was elected by the police jury, to consist of the following members: Dr. E. N. Potts, P. Trouard, Dr. A. H. Gladden, Dr. W. L. Gregory, T. L. Hood, Dr. R. L. Brooks, D. D. Wood, Alex. Myatt, F. Q. Rice and F. P. Stubbs, Jr.

The Plague is still prevailing in India, and exists in Scotland. With cholera also in India, and, particularly, with twenty-eight deaths in a week from plague in Hong Kong, it behooves the sanitary authorities of all our maritime ports to redouble their vigilance.

Typhoid Fever has increased largely within the last few months in St. Louis, some of the local physicians attributing this to the influx of sewerage from Chicago into the Mississippi river.

Notice: In the August number of the Journal, in Dr. Lerch's article, page 64, line 11, the word "flabby" should read "shotty;" page 68, line 8, the word "even" should read "especially."—Ed.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Esesentials of Medical Diagnosis. By SALOMON SOLIS-COHEN, M. D., and AUGUSTUS A. ESHNER, M. D. Saunders' Question Compends, No. 17. W. B. Saunders, publishers, Philadelphia, 1900.

The present (second) edition, thoroughly revised and considerably enlarged, of this popular book is worthy of note. Although but an outline, it continues its mission of modestly helping and directing students, while with the recent additions it might serve even for reference by practitioners. In its 417 pages the book contains the essential diagnostic signs and symptoms of over 280 diseased conditions. This indicates brevity, and as with the latter accuracy and reliability are associated, it invites students and practitioners to turn to this book at once for reference at a moment's notice. It is a useful book in its scope, carefully edited and published.

DUPAQUIER.

A Dictionary of Medicine and the Allied Sciences, by ALEXANDER DUANE, M. D. Lea Brothers & Co., 1900.

In his professional reading every physician has to consult a dictionary. The latter must contain really useful terms and succinct information on the latest phase of the medical sciences, while its size must be convenient. The present (third) edition of this work, revised in every part, enriched with a full list of dental and veterinary terms, meets all the requirements for a useful medical dictionary.

The pronunciation, derivation and definition of words are simple and clear. There is a number of tables of muscles, joints, arteries, nerves, etc., and of several varieties of bacteria, fermentations and monstrosities, the latter presenting a material not to be found in the ordinary text-books. Colored plates of practical utility appear for the first time in this edition. The skill and care of the printers have rendered possible the addition of matter equivalent to many pages without any apparent increase in size. It is a most commendable presentation of compact and condensed matter.

DUPAQUIER.

A Text-Book of the Medical Treatment of Diseases and Symptoms, by NESTOR TIRARD, M. D., London, F. R. C. P., adapted to the U. S. Ph. by E. QUIN THORNTON, M. D. Lea Brothers & Co., 1900.

This is an eminently practical work, a most useful guide in the actual treatment of the patient at the bedside. A special work on treatment, it

illustrates the fundamental principle of Therapeutics proper in meeting the indications furnished by the investigation of causes, morbid processes and prominent symptoms. It thus suggests the proper time and place to make use of the knowledge of drugs in the treatment of any individual disease or symptom, while the knowledge of diseases and symptoms for which any particular drug may be employed without guide would afford nothing at the bedside. As the author hopes, his book will certainly be found helpful and suggestive. DUPAQUIER.

International Clinics, Vol. II, Tenth Series, 1900. J. B. Lippincott Company, Philadelphia.

When, nine years ago, this periodical appeared, it received the cordial reception it merited. The original object of this quarterly has been pursued with remarkable tenacity, and at present it has a permanent place in medical literature. Like its predecessors, the volume now before us is replete with very instructive lectures and illustrations. Among the latter, as a frontispiece there is a kromogram, the reproduction of an ovarian cyst in its proper colors, by the kromscop, a new invention. It is idle to say that the great care with which this periodic is edited and presented entitles it not only to praise but to actual support from the working and reading class of physicians. DUPAQUIER.

A Text-Book of Practical Medicine, by WILLIAM GILMAN THOMPSON, M. D., New York. Lea Brothers & Co., 1900.

A Text-Book of the Practice of Medicine can be reduced to a pleasant and attractive size if, as the author of the book now before us says, only those facts and principles which have received clinical proof are set forth clearly and simply, avoiding those theories which have merely a speculative basis. Though a summary, Thompson's Practical Medicine is comprehensive, including some of the long-tried personal experience of the author in rarer cases and in deductions concerning treatment. The latter is carefully and especially considered. A number of illustrations supplement the very neat text. The author's aim has been reached in writing a comprehensive review of the present status of medical practice, and whoever purchases the book will not regret having done so. DUPAQUIER.

Injuries to the Eye in their Medico-Legal Aspect. By S. BAUDRY, M. D. Translated from the original by ALFRED JAMES OSTHEMER, JR., M. D., revised and edited by CHARLES A. OLIVER, A. M., M. D., with an adaptation of the Medico-Legal Chapter to the Courts of the United States of America, by CHARLES SINKLER, ESQ., Member of the Philadelphia Bar. The F. A. Davis Co., Philadelphia, 1900.

This unique little work will prove of great use and interest to all special workers in ophthalmology and in medical jurisprudence. To the general practitioner who desires to keep abreast of medical progress it will afford several hours of pleasant reading and many useful and illuminating hints.

H. D. B.

PUBLICATIONS RECEIVED.

Transactions of the Southern Surgical and Gynecological Association, Vol. XII.—Published by the Association, 1900.

Practical Urinalysis and Urinary Diagnosis, by Chas. W. Purdy, M. D.—F. A. Davis Co., Philadelphia, New York and Chicago, 1900.

Original Contributions Concerning the Glandular Structures Appertaining to the Human Eye and its Appendages, by Adolf Alt, M. D. —American Journal of Ophthalmology, St. Louis, Mo., 1900.

Lessons on Anatomy, Physiology and Hygiene of Infancy and Childhood, by Alfred Collon, M. D.—Medical Book Co., Chicago, 1900.

Surgery, Its Theory and Practice, by William Johnson Walsham, F. R. C. S., etc.—P. Blakiston's Son & Co., Philadelphia, 1900.

Cancer of the Uterus, by Thos. Stephen Cullen, M. B., and Max Brodel and Hermann Becker.—D. Appleton & Co., New York, 1900.

Christian Science and the Practice of Medicine.—The Edward Keogh Press, Milwaukee, 1900.

Report of the Mortuary Record of the Mutual Life Insurance Co. of New York, from 1843 to 1898.

Studies in the Psychology of Sex, by Havelock Ellis.—F. A. Davis & Co., Philadelphia.

Medical Diseases of Infancy and Childhood, by Dawson Williams, M. D.—Lea Brothers & Co.. Philadelphia and New York.

Reprints.

Clinical and Pathological Observations on Some Early Forms of Epithelioma of the Skin, by J. A. Fordyce, M. D.

Educational and Legislative Control of Tuberculosis, by Chas. Dennison, M. D.

Aestivo-Autumnal Fever in New Orleans, by H. A. Veazie, M. D.

Should Military Medical Science be Taught in our Medical Colleges, by Edmund Cone Brush, M. D.

Preliminary Note on the Viability of the Bacillus Pestis—Formalin Disinfection of Baggage Without Apparatus, by M. J. Rosenau.

Aortic Regurgitation With Remarks Upon Flint's Murmur and Paroxysmal. Sweating—The Immediate and Remote Effects of Athletics upon the Heart and Circulation—Acute Enlargement of the Tyroid Gland, with Report of Cases—The Diagnosis of Chlorosis and Chloro-Anemia, by Alfred Stengel, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR AUGUST, 1900.

CAUSE.	*White.....*	*Colored...*	*Total .....*
Fever, Malarial (unclassified)	4	2	6
" " Intermittent	1	.....	1
" " Remittent	.....	2	2
" " Congestive	.....	2	2
" " Typho	2	2	4
" Yellow	.....	.....	.....
" Typhoid or Enteric	5	.....	5
" Puerperal	.....	.....	.....
Influenza	.....	.....	.....
Measles	.....	.....	.....
Diphtheria	1	.....	1
Whooping Cough	.....	1	1
Apoplexy	10	4	14
Congestion of Brain	1	2	3
Meningitis	5	5	10
Pneumonia	13	6	19
Bronchitis	4	1	5
Cancer	6	3	9
Consumption	36	26	62
Bright's Disease (Nephritis)	17	19	36
Uremia	.....	.....	.....
Diarrhea (Enteritis)	12	6	18
Gastro-Enteritis	.....	3	3
Dysentery	4	1	5
Hepatitis	1	.....	1
Hepatic Cirrhosis	3	.....	3
Peritonitis	2	1	3
Debility, General	.....	1	1
" Senile	13	6	19
" Infantile	3	5	8
Heart, Diseases of	16	13	29
Tetanus, Idiopathic	.....	.....	.....
" Traumatic	2	6	8
Trismus Nascentium	2	7	9
Injuries	22	5	27
Suicide	2	1	3
All Other Causes	61	57	118
TOTAL	248	187	435

Still-born Children—White, 26; colored, 17; total, 43.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 14.17; colored, 24.93; total, 17.40.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.06
Mean temperature	82.
Total precipitation, inches	4.19

Prevailing direction of wind, southeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. NOVEMBER, 1900. No. 5.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

ALCOHOL AS AN ETIOLOGIC FACTOR IN DISEASES OF THE NERVOUS SYSTEM.*

BY E. M. DUPAQUIER, M. D., PROFESSOR ON CLINICAL THERAPEUTICS IN THE NEW ORLEANS POLYCLINIC, NEW ORLEANS.

The present paper being only a synopsis of the first part of the subject "Alcoholism," which Dr. P. E. Archinard, as chairman of the Section on Neurology, Dr. G. A. B. Hays, of Jackson, La., and myself intend to fully develop at the next meeting of the Louisiana State Medical Society, it shall be limited to general considerations without going into details of facts and observations. As a preliminary, it is proper to state that facts (personal and compiled), only facts, are depended upon to determine before the sceptic the potentiality or possibility of alcohol as a capital etiologic factor in diseases of the nervous system; in other words, the standpoint taken is scientific.

No feelings born of prejudice should be allowed to guide us in proceeding to investigate this profoundly scientific and far-reaching social subject.

Insanity and nervous diseases on the one hand and the consumption of alcohol on the other have rapidly increased, everywhere.

*Read before the Orleans Parish Medical Society, September, 1900.

But, nowhere, as far as I personally know, nowhere more than in France have both these contemporaneous facts been remarked and actually figured out; nowhere, insanity, nervous diseases, physical and moral degeneration on the one hand and alcoholism on the other have been more closely studied; nowhere, have the relation and connection between the disorders of the nervous system and the consumption of alcohol been more strikingly demonstrated; nowhere, has the medical profession shown more ability in pointing out the dangers of and the remedial measures against alcoholism.

In studying this capital question "alcoholism," which, as stated above, is a *universal* one, it is natural that we should derive most of our information from French sources and follow the example of the élite of the medical profession of France in proving: First, the dangers of the use of alcohol; and second, in stamping out alcoholism which, hand in hand with tuberculosis and cancer, constitute a more dreadful trio than the epidemic diseases of former days.

From records, I know that in one institution for the insane and nervous diseases, out of 100 cases of very distinct toxic origin, 54 were due to alcohol alone, and out of the remaining 46 due to ether, morphin, chloral, cocain, lead, 20 presented a distinct family history of alcoholism.

Out of 30 exact types of common nervous diseases, 15 are distinctly of alcoholic etiology, or in other words, alcohol occupies an important rank among their distinctly established causes. They are:

1. Multiple neuritis; 2. glosso-labio-laryngeal paralysis; 3. chronic meningitis; 4. edema of the brain; 5. cerebral hemorrhage; 6. acute delirium; 7. paretic dementia; 8. encephalitis; 9. epilepsy; 10. infantile convulsions; 11. choreiform affections; 12. tremors; 13. neuralgias; 14. hysteria; 15. neurasthenia.

Of the other nervous types in which alcohol does not figure as an *etiologic factor*, there are many with indefinite etiology, such as inherited neurotic condition, toxemia, which, if closely investigated, might be referred to alcoholism in the antecedent or in the personal history of the case. Why? Because in all doubtful etiology, the universal use of alcohol presents itself to the thinking mind, and, as a result, we know that human beings

have for centuries been impregnated with alcohol. Hence, why should not *alcohol* be at the bottom of such indefinite cases? Aside from alcoholism manifestly giving rise to the marked types, we know there results from the alcoholic impregnation spoken of as latent alcoholism, an insidious alcoholism, which is the main source, I believe, of "hereditary neuropathy" in all classes, and which in the so-called better class, the physician can not detect (*signe de Quinquaud*) without offending the susceptibility of his patient (*alcolisme chez les gens du monde, Thèse. Legrés*). The whole of the nervous system is affected by alcohol, so, whatever nervous disorder of indefinite etiology presents itself in the domain of motion, sensation, reflex action, nutrition, electric reaction and cerebral functions, we are tempted to refer it to alcohol, on account of its universal use and of its universal action as regards the nervous system, directly by artificial stimulation of the neurons and the axis-cylinders, indirectly by the cardio-vascular alterations, the arteriosclerous process of which alcohol is the chief factor. So, in a large measure, one can attribute to alcoholism under its mildest as well as its severest forms, stated above, some of the many cases of constitutional imbecility, idiocy, cretinism, acquired dementia, of the large class of insanity proper with its two types, mania and melancholia, and of the important class of partial insanity without general morbid reaction whose delusions are persecution, mysticism, ambition and grandeur. In addition to the degenerates of the mind, including the moral sphere, we may attribute in a large measure to alcoholism some of the cases of spinal infirmities and hereditary trophic deformities of indefinite etiology.

To explain this view a little stress might be laid upon the alcoholic impregnation mentioned above. As a result of accepted but erroneous ideas about wine, beer, whisky and other national drinks, human beings are impregnated with alcohol at the beginning of their intrauterine life. Let us follow the evolution:

First—Father and mother themselves from their daily innocent use of alcohol have impregnated with it all their cells and tissues, consequently their spermatozoid and ovule, which meet and unite in hot radiant asterisks to start their fetus, are stimulated under a whisp of alcohol.

Secondly—The child's blood is carrying the alcohol which its mother takes *during pregnancy* (compiled obs. experiments)

and also *during labor*, for not uncommonly the parturient is stimulated with alcohol, and in rural districts (personal observation) high doses of it are given to numb pain.

Thirdly—From early extra-uterine life the babe takes the alcohol carried in his mother's milk and later on he takes it with his meals. Hence the alcoholic impregnation of human beings.

There lies the danger. The question arises whether alcohol is a necessity of life. The answer is emphatically *no*. Alcohol is a drug and belongs to the materia medica. Alcohol, with its chemical symbol C_2 H_5 OH, ethyl hydrate, is a very active medicinal agent, the physiologic action of which we are certain. This should receive more consideration from the great majority of innocent people who have come to use it as an every day necessity of life, a beneficial article of food, if taken in the very elastic measure or dose permitted by rules of decency and morals. The prospects of limiting the use of alcohol to medicinal purposes, and allowing physicians only to dispense it, seem to be utopian as yet, for buildings and distilleries are being erected everywhere, new drinks are multiplying, and liquor vendors are cropping out all over the civilized and uncivilized globe, while asylums for the insane and sanitariums for nervous diseases are crowded and medical men are overburdened with cases of hysteria, neurasthenia and other inaccessible psychoneuroses.

If the public knew that with the very best and purest alcohol they are taking as a pleasant and useful article, they are also taking other harmful drugs and even strong poison which the greed of commerce suggests, through sophistications, and begets through lack of proper distillation and storage, or through the addition of artificial bouquets or chemical aroma. Furfusol, or amyl alcohol, which disappears with age, a terrible poison, is found in bottled brandy under the label of the best and oldest brandy. Oils for the bouquet are as poisonous as absinthine, while clarets are commonly alcoholized or charged with impure alcohol and fermentations arrested by salicylic solutions. If the public knew all this, or thought of it, the prospects of abating the mischief caused by alcohol might appear at hand. Enough has been said so far to show that in looking for the cause of the increase of insanity and nervous diseases, it is obviously proper to direct our attention to the present universal

habit of using alcohol freely as a food or in preparing food, as a drink or in preparing drinks, at home and outside of home, in all stations of life and for all ages.

The link connecting these two contemporaneous facts, viz., increase of nervous diseases and increase of consumption of alcohol, is the universal action of alcohol on the nervous system, the purest alcohol, the laboratory alcohol, as well as the impure alcohol, and dangerously aromatized alcohol under all forms of drinkables on the market.

It is self-evident that the results of use and abuse of alcohol are similar in kind and different in degree and extent only. The use as well as the abuse creates a pathologic condition which, though mild and apparently innocuous, is bound to tell directly or indirectly on the user or his descendants. Between the simple habitual stimulation by the constant use of alcohol to the excessive stimulation by the constant or the periodic paroxystic dypsomanic use of alcohol, what is the difference? Only a matter of degree. Use or abuse, the nervous system is in all cases uselessly and abnormally stimulated until it is altered and stamps man's progeny with a defective nervous system. Hence, the conclusion forces itself upon our mind that from the simple "irritability," acquired or hereditary, to the common manifestations of acute alcoholism, drunkenness, mania a potu and the somatic conditions of chronic alcoholism and delirium tremens, it is all but a matter of degree. The etiology is the same, the use of alcohol.

The sophists or captious and fallacious reasoners may call us cranks. Well, I am willing to be called a crank if I am in the company of the medical elite, but I desire to meet the sophist's arguments. The first is that from the remotest time men have used alcohol; that we are used to it; that most of it is promptly eliminated. Now, then, the fact that tolerance to a poison can be established by prolonged use does not show that the poison eater is at all superior to his kin or that his descendants have derived in any way any superiority in mind and body from their father's habit. The contrary is true. The opium eater of the Orient and the arsenic eater of the Tyrol have not set a very encouraging example in that regard to their co-relative, the alcohol user. If exceptionally we hear from history, or see among our contemporaries poison users of extraordinary cerebral

powers, we can not attribute their superiority to the use of poison, for we learn from history and see among our contemporaries men of equally great talent and genius who live on plain food and drink plain water. This craving for poison is pathologic, and is seen in nervous mal-equilibration, and the use of the poison still aggravates the morbid condition. So we have an unbroken chain of morbid conditions acquired and transmitted to the following generations.

The second argument of the sophists is that alcohol is a food. Yes, a fact, and a certain one, it is. Who said so? Doctors? Yes, because we use it in diseased conditions as a therapeutic agent for supplying food when plain food can not be taken. But in healthy condition men do not require food in that form. In healthy conditions and in ordinary circumstances in the tropic as well as in the arctic regions, in the valleys or in the mountains, on land or on sea, men feed on wholesome food, plain cooking, and drinking plain water, derive more constant nerve energy and force than those entirely or partly fed on alcohol (reports of army, navy, compiled observations, personal observations). Fatigue is a pathologic condition, and therefore after the vital energies have been spent, when men must rest and lie down, alcohol is indicated as a food and therapeutic agent; but after the fatigue is over, for the patient's sake, stop alcohol as a food.

The other argument of the sophists is that life without alcohol would be monotonous. In the first place, without alcohol, a man in good health can be in high spirits and merry without being in his cups. Cheerfulness, sprightliness, sportiveness, merry sayings, merry doings, charitable and generous feelings, are not dependent upon alcohol. It may be that alcohol begets wild and boisterous mirth, but it is that pathologic and hysteric mirth we see in banquets and politic assemblies; not that soothing and cheerful temper of man in good health. I like true gaiety; I hate the man, the joker, full of alcoholic fun. And, secondly, if one seeks a pleasant life, gentlemen, one must take life *au serieux*. I do not mean to say that we should look upon all these circumstances dependent on alcoholism as tragic, but as being most serious. I am speaking to physicians, to thinking brains, to serious men and good citizens, that is all.

REPORT OF A CASE OF ACUTE PHOSPHORUS POISONING WITH DEMONSTRATION OF POST-MORTEM FINDINGS.

BY J. B. GUTHRIE, M. D., CLINICAL ASSISTANT TO THE CHAIR OF GENERAL CLINICAL AND OPERATIVE SURGERY IN THE N. O. POLYCLINIC; ASSISTANT TO THE CHAIR OF MATERIA MEDICA AND THERAPEUTICS, TULANE MEDICAL DEPARTMENT.

HENRY K., a white male child, 2 years of age, was brought to the accident room of the amphitheatre of the New Orleans Charity Hospital at 4 P. M., November 9, 1899. From the attendant who came with him, the following history was obtained: Patient had been for some time an inmate of one of the infant asylums of the city. On the night previous to the day of admission, Stearne's Rat and Roach Exterminator had been used in the institution whence he came, for the purpose of killing vermin. The paste is a combination of phosphorus and had been spread upon thin slices of bread about 2 inches square and distributed about the floor. An effort had been made on the following morning to gather up the bits of poisoned bread, before the children were admitted to the room. Evidently one of the pieces escaped notice and the little fellow was supposed to have eaten it. The exact quantity of phosphorus taken, could not, of course, be determined. The child had been suffering since 8 A. M. of the day of admission (November 9, 1899). It is certain that he had swallowed the phosphorus that morning, for it was not put upon the floor until after the children were in bed the night before. He had been crying and had vomited everything in the way of nourishment which had been given him since 8 o'clock, when he first showed signs of being sick. Bowels had moved several times. The nurse could not tell how often, but said stools were watery.

When first seen was in a stupor. Eyes were wide open and child was not crying. He seemed perfectly conscious. Pulse was 140 air and very compressible. Rectal temperature normal. No jaundice was observed at this time, nor at any time afterward.

Stomach washing was performed immediately. Child resisted the introduction of stomach tube. Several gallons of warm sterile water were first used. This was followed by about a 10 per cent. solution of peroxide of hydrogen. A quantity of this solution was used and afterward sterile water again. Following this last lavage, acid oil of turpentine next was introduced into stomach through tube and allowed to remain. In the washings

from the stomach and in the breath I could detect no odor of phosphorus. There were no particles washed out other than a few flecks of mucus. The first water withdrawn from stomach had a faint brownish tinge; later it came back clear.

Patient was sent to the ward about 4:30 P. M. In ward cried several times and seemed to be suffering pain in epigastric region. Nourishment in the form of milk, which he drank greedily, was vomited immediately. Watery discharges from bowels continued, and pulse became more and more rapid and temperature sub-normal. Condition of stupor deepened until death occurred at 12:30 A. M., November 10, 1899, sixteen hours after first symptoms appeared. A few hours before death patient became cyanosed and respirations were very rapid. Auscultation of lung revealed a few sub-crepitant râles at the bases of both lungs posteriorly. Treatment consisted in calcined magnesia in teaspoonful doses every two hours, and strychnin sulphate, gr. 1-300 by hypodermic every four hours. Vomit never had "coffee-grounds" appearance. Urin was voided with stools, but its quantity could not be measured nor could a specimen be obtained for examination.

I was present at the autopsy which was held at 1 P. M. November 10, 1899, by Dr. O. L. Pothier, the pathologist of the hospital. At the autopsy we observed the following:

Post-mortem held 10½ hours after death on body of white male child, well nourished. Ecchymotic spots in skin of head, trunk and limbs. These spots occurred even on the anterior surface of the body which had been resting on back since death.

Cadaveric rigidity was well marked.

Sclerotics were not at all discolored.

Pupils were dilated.

Heart was empty and felt soft to the touch. Petechial spots were noted under both visceral and parietal pericardium. These were more numerous at the base of organ and over the origins of the great vessels. No ecchymosis could be seen in endocardium. Valves were normal. Myocardium presented no gross evidence of disease. Weight of heart 2½ oz.

Lungs showed congestion and on compressing a section more than the usual amount of blood exuded. Weight of lungs: right 3 oz.; left 3¼ oz.

Liver was mottled upon free surface and surface of section

when cut. Faint, tawny, yellowish spots irregular in outline, appeared upon a red background of normal liver color. This marking was most distinct in the superficial portions of organ, immediately underlying the capsule. Gall-bladder was full of bile. Weight of liver 17½ oz.

Spleen was enlarged, engorged with blood and bright red on section. Splenic pulp was more friable than normal. Weight of spleen 3 oz.

Pancreas presented no abnormality. Kidneys showed a capillary injection here and there upon the surface and in parenchyma when cut. Capsule was not adherent and peeled off readily, leaving smooth, shining surface. When cut in long diameter, blood oozed from the organ and cortex appeared paler than medullary portion. Fatty degeneration was evident from the color of the organ on section. Areas of fatty degeneration could be made out perpendicular to external surface. No arch-like bands could be seen between cortical and pyramidal portion, such as Dr. O. L. Pothier has described in cases of fatty degeneration resulting from yellow fever. Weight of kidneys: Right, 1½ oz.; left, 1½ oz.

Stomach was contracted and empty. External surface was somewhat redder than normal, but no extravasations of blood could be seen. On opening organ the mucosa was found engorged. The whole interior was red, more intense and a littel deeper in color at the cardiac extremity. There were no erosions of stomach lining. Stomach was taken into photographic dark room and its interior examined for phosphorescence. None was noticed.

Small intestines were, like the stomach, contracted. They were almost empty and contained only a small quantity of chylous fluid. In duodenum, and upper jejunum, peritoneal surface was red and congested, but with no capillary hemorrhages. This congestion diminished further down. No erosions of mucous membrane could be found. There was, however, a marked engorgement of Peyer's patches, which were red and swollen and stood up above general internal surface of gut.

Large intestines presented no gross pathologic lesion.

Urinary bladder was partially distended and the urin drawn from it after death furnished a rich field for study. The specimen was remarkable for the quantity and variety of the

anatomic constituents it contained, as the following analysis made by me will show:

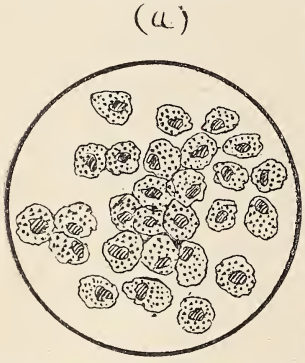
Specific gravity:—Specimen too small to float urinometer.

Reaction strongly acid.

Albumin, moist, 3 per cent. (Esbach's method).

Sediment contained the following: — Leucocytes, in great excess (they were large in size and hyalin, exhibiting few granules); epithelium, apparently from all portions of the urinary tract in great quantities. This epithelium made up by far the greater part of the precipitated sediment.

The following varieties of epithelial cells were noted: (*a*) Small round cells with prominent nucleus. These occurred singly and grouped, with tessellated arrangement, and also adherent to large epithelial cells (see below); (*b*) spheroidal cells resembling (*a*), but in these cells, while in some cases the nucleus stood out dark against the cell-body, sometimes it was not so prominent or even obscured owing to granular condition of the protoplasm; cells of this type like (*a*) were found grouped and adherent together, and unlike (*a*) cemented together with a matrix of hyalin material forming casts of the epithelial variety. (*c*) Spindle-shaped and caudate cells with a single prominent nucleus excentrically placed and containing finely granular matter. These cells were seen in all stages of granular degeneration, exhibiting more or less coarseness of protoplasmic granules. They occurred one at a time and often having adherent to them one or more cells of type (*a*). Occasionally one of these lenticular cells would be completely covered by a layer of the small spheroidal cells (*d*). Columnar cells oc



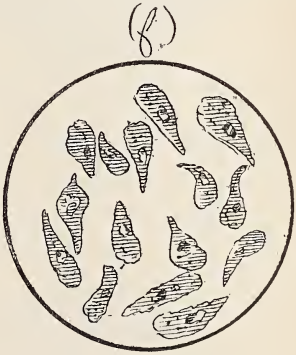




casionally exhibiting a greenish yellow pigmentation (*e*); very large squamous cell, polygonal in shape with well marked nucleus. These also were at times seen completely covered with adherent transitional spheroidal cells. (*f*) Pyriform cells of large size, occurring singly with only very fine granules visible in cell substance. The nucleus in these larger pyriform cells was was in most cases nearer the caudal end of the cell. (*g*) Smaller caudate cells, pyriform in shape, but more granular than (*f*), with nucleus near bulbous portion of cell (*g*).







The above includes the epithelium which was most abundant and most typical. Variations in shape were noted quite frequently.



A few large hyalin casts were found, but the tube casts which were present in greatest numbers were granular and finely granular. Almost every field (using 1-5-inch objective and 1-inch eye-piece and 9-inch tube) contained 4 or 5 casts of this type.

Epithelial casts were of two kinds; one almost perfectly transparent, evidently renal epithelium imbedded upon a hyalin base; the other with similar cell arrangement, but in these the basis of cast seemed granular.

Oil globules were seen free in the liquid and in a few of the cells of type (*b*). I did not note any fat droplets within the cell substance of any of the larger epithelial cells.

Besides the above constituents, mucus and amorphous urates were seen, but no crystalline urates.

Stained sections of heart, liver and kidneys were examined microscopically. I have also prepared photomicrographs of these organs which are shown below.

In the heart the characteristic situations of the muscle fibres are in places invisible even with the higher powers. Throughout

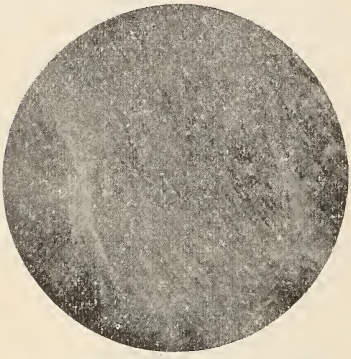


Fig. 1. Heart mnscle—high power.



Fig. 2. Kidney cortex—low power.

section there is a dimming of these striations owing to fatty degeneration. Here and there I noted fibres whose protoplasm seemed to be almost disintegrated. The fatty degeneration was not uniform, affecting parts of the muscular tissue and leaving other parts almost normal.



Fig. 3. Kidney cortex—higher power than Fig. 2.



Figi 4. Glomeruli—high power.

The liver showed a granular condition of hepatic cells. They were, as a rule, swollen, and had lost the sharp polygonal outline. The lines of separation between cells as between lobules was indistinct and hazy. In the liver, like the heart, the paren-

chymatous change was not uniform, some parts showing fatty degeneration to a much greater extent than others. Throughout the liver tissue were pigmented spots. Whether or not these deposits of pigment bore any relation to the primary cause of death, I can not say.

It is in the kidneys that the most striking pathologic condition was apparent. In these organs there was a diffuse parenchymatous change. Cloudy swelling was to be seen throughout the renal epithelium, in both cortex and medulla. In the cortex the blood vessels were dilated and their walls thickened. Considerable infiltration of leucocytes into the stroma in neighborhood of these dilated blood vessels had occurred. In Bowman's capsule there was a marked separation of the two layers of epithelium, there being considerable distance between the layer covering the glomerulus, and the reflected or parietal layer which is continuous with the convoluted tubule. The glomerulus seemed as if shrunken.

The parietal layer of Bowman's capsule shows a desquamation of cells forming it. These cells appear in a state of degeneration and are peeling up from the cavity which they line. The shrinking of the glomerulus and increased opacity of epithelial layer of cells covering capillary tuft is characteristic of the acute desquamative nephritis of phosphorus and arsenic poisoning, and of yellow fever. Section through secreting tubules, whether in cortex or medullary portion, shows the same granular and hazy condition of all cell substance and indistinct cell outline, all the more apparent here because of the very sharp outline of the epithelium of the tubules in the normal kidney. In some of the tubules the cells lining them were completely broken down and blended. In the lumen of the tubules there was often granular detritus. Some of the secreting tubules contained hyalin matter. The collecting tubules likewise showed degeneration of epithelium. They were in places dilated and also contained hyalin matter.

In this case we have seen death result in about sixteen hours after the ingestion of the poison. The phosphorus was taken in a very finely divided form, the best condition for rapid absorption. It may be that the dilution accounted for the lack of phosphorus burns upon mucous membrane of lips, mouth and pharynx, together with absence of erosions in stomach.

The rapidity of the course of the toxic process would make jaundice less apt to be expected. According to Witthaus and Becker, jaundice is the rule, and those few cases in which it does not occur are those in which death results early. This symptom was altogether wanting during life and no post-mortem evidences of pigmentation with bile could be seen, excepting that occurring in some of the large cylindric epithelial cells found in the urin.

The duration of the disease was very much shorter than what is usual in this form of poisoning. Of course, in a child we should expect this, and we should not look for such extreme changes in the organs as would occur in an adult, as, for instance, steatosis of the voluntary muscles. Death came before these occurred. However, the case is a striking one as illustrating the very acute nature of phosphorus poisoning. It is astounding to see how much damage was done and in how short a time. It is very apparent from the *post mortem* results, that death resulted from changes in the viscera, brought about in a few hours by a toxic substance disseminated in the blood.

What is remarkable, and what does not receive much notice in the standard text-books on toxicology, is the character of the urinary sediment. At the risk of becoming tedious, I have tried to describe this minutely in order to show the sudden and extensive desquamation of the urinary tract. I believe I have been able to show by this analysis the presence in the urin of every typical form of epithelium from that of the renal tubules downward. The renal epithelium is easy to demonstrate and identify, because of its occurrence, besides singly in groups, upon hyalin and granular base, in the form of epithelial tube-casts. In a few of the renal cells only I found fat droplets. Free oil globules were quite plentiful.

The desquamation below the kidney tubules seems to have involved more than one layer of cells, for large epithelial cells almost if not quite covered with spheroidal cells of transitional epithelium firmly adherent to them were visible in almost every field.

I regret that I did not make a blood count and hemoglobin estimate when the case was first seen, for it is in the early stages of phosphorus poisoning that according to Von Joskch the greatest polycythemia is observed. Von Joskch records a case where

the number of red blood corpuscles reached 8,650,000 per cubic millimeter with a diminution of number of leucocytes and without an increase in the percentage of hemoglobin. The blood count might be of value in a doubtful case as a help to diagnosing the early stages of poisoning if a definite history were lacking.

It would be very possible in the event of a false history being given in a case like this one of a young child, for the unsuspicious practitioner to overlook phosphorus poisoning as a cause of death, and attribute it to acute gastro-enteritis, which sometimes runs just as rapid a course and presents some of the symptoms which were manifested here.

A NOTE ON THE MEDICAL RELIEF WORK DONE IN GALVESTON AFTER THE STORM.

BY ISADORE DYER, M. D., NEW ORLEANS.

While here and there the lay press has referred to the relief work in Galveston at the hands of volunteer medical men, the history of this part of the Galveston disaster has yet to be written.

It has seemed to us that we should not pass altogether by without a word of praise for the excellent work done by the Galveston medical profession, volunteers from elsewhere as well as from Texas, and the several newspaper relief corps of doctors and nurses sent to meet the contingencies.

The world had hardly learned of the almost unthinkable cataclysm, when the local medical men were organized for the dispensary and hospital care of the ill and wounded. Fortunately the John Sealy Hospital was not damaged enough to prevent its almost immediate usefulness. After a few days even St. Mary's Infirmary was available. The City Board of Health, assisted by a number of city practitioners under the chairmanship of Dr. Trueheart, an old and talented gentleman in practice in Galveston, formed an auxiliary committee and subdivided into district committees whose function it was to establish necessary hospital facilities at the various points of need.

Under this arrangement the city was provided with several emergency hospitals, under roof and tent, where ready service was at first rendered night and day.

Among the men of Galveston who were on duty in the service were: Drs. C. H. Wilkinson, C. W. Truehart, H. A. West, Geo. H. Lee, A. F. Sampson, John Hayden, H. P. Cooke, Ed. Randall, G. A. Dilllinger, W. C. Fisher, C. T. Peckham, W. L. Rogers, and others.

Of volunteers from elsewhere were Drs. C. P. Wertenbaker of the U. S. M. H. S. (sent from the New Orleans Station), R. H. Harrison, of Coleman, Texas, besides a number of men from the corps of the New York *Journal*, Philadelphia *North American* and Chicago *American*.

At the Ball High School, the *N. Y. Journal* had a well-equipped hospital; at the foot of Tremont street and the Beach was a tent hospital under Drs. Peckham and Wertenbaker, and at the U. S. Customhouse a hospital and dispensary under the charge of Dr. A. F. Sampson, assisted by Dr. R. H. Harrison and a staff of several surgeons and nurses.

At the last named dispensary I had occasion to offer service during my stay in Galveston, and have been able to secure a record of the work done here for the relief of those in the district, near and about the Customhouse. The surgeons in charge as residents were Drs. H. A. Cassett, of the staff of the New Jersey State Hospital, at Jersey City, and S. L. Cash, of Bellevue Hospital, New York. There were here in addition, Drs. F. L. Christian, New York; John B. Sewell, Franklin, La.; A. R. Kuykendall, Morgan, Texas; Dr. Lambkin, of Alabama, and Dr. Houghton, of New York. The nurses on the staff were as follows: Miss Emma Hinton, of Los Angeles, Cal., chief nurse, and Misses Madge McKenzie, Galveston; Lima H. Demy, Woodlawn, Ala.; Maud M. Robinson, Little Rock; S. W. Smith, Galveston, and Della Weeks, Des Moines, Ia. Mr. C. W. Rogers, of Carbondale, Penn., acted most efficiently as male nurse and assistant.

Perhaps some day the medical men in Galveston may think it important to record as a whole the work done under stress of emergency, and these lines are written to urge the opinion that the study of injuries, wounds and emergency cases is sure to add a few items of value from the point of statistics and history, if not from a clinic point of view.

Through the courtesy of the Deputy Collector in Galveston, Mr. J. N. Rosenthal, I have been able to get a copy of the

records kept at the Customhouse Hospital, showing all cases treated from September 14 to September 25, when all emergency hospitals were closed, as the general hospital was ready and able to care for all cases presented.

The most striking point in interest was the comparatively small number of those seriously injured when the fearful loss of life is considered. It is generally conceded, however, that the force of the storm was as great as sudden, and that those who were dangerously hurt were drowned before they might have been saved. It is likely that each of the divisions of medical relief may be duly interested in making some statistic report, as it may prove valuable by comparison in the future study of accidental wounds. With that belief we have seen fit to present the following brief statement of the cases handled at one of the district hospitals, the U. S. Customhouse above referred to.

In the eleven days of operation, over 1500 cases were prescribed for, visited, treated in hospital ward or were dressed in the dispensary. Under the circumstances some cases applied for and received treatment which might not properly be called emergency cases, but with existing conditions, discrimination was out of the question.

The following table shows the cases treated and offers the opportunity for the conclusions which follow.

SURGICAL CASES.

	Cases.
Abrasions (foot, 1; unclassified, 1)	2
Abscess (breast, 1; unclassified, 1)	2
Bruises (ankle and leg, 1; arm, 2; face, 1; foot, 2; unclassified, 3)	9
Contused wounds (hand, 2; leg, 2; knee, 3; side, 1; unclassified, 2)	10
Contusion and laceration of face, 1	1
Incised wounds (abdomen, 1; arm, 1; eyelid, 1; face, 1; fingers, 2; foot, 12; forehead, 2; great toe, 1; hand, 7; head, 1; leg, 3; shoulder, 1; unclassified, 3; head and foot, 1)	37
Dog bite, hands and chest	1
Punctured wounds: Right foot, 3; toe, 1; forearm, 2; cheek, 1; unclassified, 2	9
Cut and bruised hands and legs, 1	1
Fracture: Rib, 2; arm, 2; skull, 1; humerus, 1	6
Dislocations: Thumb, 1	1
Sore leg	1
Wounded leg, 5; scalp, 1; hand, 2; feet, 1; back, 1	10

SURGICAL CASES—*Continued.*

	Cases.
Crushed finger, 1	1
Nail puncture in foot, 4	4
Internal injuries, 1	1
Lacerated wounds: Hand, 3; head, 1; arm, 1; leg, 1; unclassified, 1	7
Synovitis of arm	1
Septic edema	1
Splinter in foot	1
Traumatic edema	6
Sprains: Leg, 2; with cuts on leg, 1; wrist, 1	4
Necrosis: Tibia	1
Cellulitis: Leg	1
Periosteum located on left arm, infected wound	1
Traumatism: Upper left arm	1
Tetanus from scalp and foot, incised wounds	1
Dermatitis colorica (water and sun)	2
Total	123

MEDICAL CASES.

	Cases.		Cases
Rheumatism	9	Nervous prostration	5
Remittent malarial fever	4	Fever and nausea	5
Malaria	4	Hernia	2
Traumatic pleurisy	3	Headache	3
Otorrhea	4	Orchitis (traumatic)	1
Inflammation of eyes	3	Conjunctivitis	2
Concussion of brain	1	Cholera morbus	2
Myositis	1	Debility	1
Pleuritis	3	Diarrhea	4
Colitis	3	Bronchitis	2
Mastoiditis	1	Nephritis	1
Gastrititis	3	Cramps from exposure	8
Cardiac weakness	1	Bilious	1
Indigestion	10	Enuresis	4
Cystitis	1	Hysteria	1
Urethritis	1	Enteritis	2
Lumbago	4	Sclerotitis	1
Intestinal hemorrhage	1	Syphilis	3
Vertigo	1	Medicine given and undiagnosed cases	24
Weakness from exposure	1		
Tonsilitis	1		
Hemorrhoid, ext	1	Total	133

One is struck with the general mild character of injuries handled at this hospital. Of course, the place was opened 4 days after relief was organized, and it may be that the early cases were sent to the Sealy Hospital. The Customhouse, however, is quite central, and the staff each day sent out some of its number to answer emergency calls, and where the indication suggested it, the patient was admitted for treatment. There were no fatalities and only a few of the patients admitted were transferred to the Sealy Hospital when the Customhouse emergency hospital was closed. Good results were had and this was due to good nurses and the supply of dressings, which though limited in variety proved adequate to all needs.

Clinical Report.

A CASE OF DOUBLE INTRA-LIGAMENTOUS CYST, WITH REMARKS.*

BY C. JEFF. MILLER, M. D., LECTURER AND CLINICAL ASSISTANT TO THE CHAIR IN OBSTETRICS AND GYNECOLOGY IN THE NEW ORLEANS POLYCLINIC.

A well nourished colored woman, 24 years of age, was transferred to the gynecologic service July 13, 1900. A history of acute illness of two months duration was elicited, which pointed to some inflammatory condition in the lower abdomen and pelvis. She had been married four years, had never miscarried but had one child three years old. The menses first appeared during her 12th year, and excepting the natural disturbance incident upon pregnancy and lactation the flow had appeared regularly every month without pain or variation in the amount. For three months prior to her admission to the hospital, however, she only menstruated one day in each month and the flow had been scant. She had not felt well during these three months. There were occasional attacks of pelvic discomfort, constipation and bladder irritation, and once she considered herself pregnant. When admitted she was suffering considerably

* Read before the Orleans Parish Medical Society, October 13, 1900.

from pain in the abdomen and had temperature which occasionally reached 102 deg. Before she was transferred to the gynecologic ward she had a profuse bloody vaginal flow which lasted nearly four days, and she felt somewhat better afterwards. Mr. Granger, the interne in charge, made a vaginal examination and considered the case one of double acute salpingitis, endometritis, and an indurated mass in the left broad ligament. She was confined to her bed, laxatives given and douches ordered twice daily. Ice bags were occasionally applied over the lower abdomen. Her improvement was so pronounced for several days that I made no vaginal examination. The temperature was only 99 deg., the pain had subsided and she wanted to sit up.

On July 22 she was suddenly seized with violent cramping pain in the lower left iliac fossa, and she claims a mass developed there in six hours which had not existed before. The menses appeared again and her temperature rapidly increased until on the second day it reached 103 deg. She was very much shocked and had almost fainted twice. On examination without chloroform a distinct fluctuating mass was detected in the left iliac fossa, which extended upward almost to the level of the umbilicus. The abdominal walls were quite rigid and extremely sensitive to touch. A hard mass was felt through the vagina, which at one point was fluctuant. The uterus was pushed downward and the whole pelvis so indurated that no organ could be outlined. Rectal tenesmus was pronounced. As a careful examination had not been made prior to the sudden onset of colic and fainting spells no conclusion could be reached as to the state of the contents of the pelvis before that time. The irregular and protracted menstrual flow, combined with the sudden attack of colicky pains and fainting spells, strongly suggested rupture of a pregnant Fallopian tube. Two days after the sudden attack mentioned above the abdomen was opened. Dense adhesions were met with throughout the pelvis and lower part of the abdomen. The omentum was unusually long and adhered extensivly over the ligament masses. Each broad ligament contained a cyst; the one on the left being the larger and reaching nearer to the umbilicus. The left also showed more evidence of acute and active inflammatory changes than the right. Deep in the left ligament, lying close to the uterus, a small fibroid about the size of a

hen's egg was found. Various small cysts were encountered on the peritoneal surface of the broad ligaments (a product of intense inflammation first mentioned by Tait). Both ovaries and tubes were enclosed firmly in the inflammatory masses lying behind the cysts. After the adnexa were freed and the ovarian vessels secured, enucleation of the biligamentous cysts was accomplished after much difficulty. Hemorrhage was so general from the raw broad ligament folds and the uterin vessels so difficult to reach quickly that it was deemed the better plan to pack the folds with gauze after sewing their edges to the parietal peritoneum about the abdominal incision. But the weak condition of the patient and continued bleeding suggested a technic much more easily performed and gave the patient infinitely better chances for recovery. It was considered best to remove the entire uterus and drain through the vagina. This was quickly accomplished, the raw broad ligaments packed with iodoform gauze and the ends drawn into the vagina. One half a gallon of hot saline solution was introduced into the veins of the left arm before the operation was completed. The patient left the table considerably shocked, but as the technic had been perfect her chances for recovery were considered good. Four hours after the operation her temperature was found to be 104 deg. F., and pulse of 132 per minute, but it rapidly subsided in three hours to 101, where it fluctuated for four days, and then declined to normal. Frequent hot saline enemata were given with most gratifying results. The gauze drains were removed on the fourth day and a loose gauze pack substituted. The patient made an uneventful recovery.

Viewing this case from a post-operative standpoint, some interesting features develop. The history given by the woman strongly suggested ectopic pregnancy, especially the disturbed menses, sudden attacks of pain and the appearance in a few hours of a mass in the left lower quadrant of the abdomen that had not existed before. The operation developed facts that will refute the sudden appearance of the cyst. It was evidently the growth of months, which gave no marked sign of its presence until inflammatory changes occurred as a result of infection, possibly from the bowels.

The technic of operations for the removal of intraligamentous growth is also a matter of constant interest and study. No pro-

cedure requires a more thorough knowledge of anatomy, delicacy of manipulation and ability to deal with the most trying emergencies. The varying position of these growths, the ease with which some may be shelled from their surroundings, and the difficulty of even properly draining others has militated against the adoption of a more generally applicable technic. In fact no one can insist upon the adoption of a single technic. It is enough to follow the general principles of pelvic surgery and meet the various complications as they present themselves. Incomplete operations were the rule, not the exception, a few years ago. At present, however, it may be questioned whether operative interference is not often carried to the extreme in the endeavor to avoid troublesome complications, chief among which is hemorrhage. As the individual surgeon's experience increases this number of incomplete operations will decrease.

Incision of the cyst wall and attaching its edges to the abdominal incision is at best an unsatisfactory operation, and no patient who has been submitted to such a procedure can be regarded as cured. The prolonged and tedious recovery due to the necessary suppurative process and consequent granulations should ever be borne in mind and avoided if the patient's vital powers will permit of more radical measures. No apology is necessary for the performance of such an operation when tumors are found deep in the pelvis, underneath the peritoneum, pushing their way upward into the abdominal cavity separating the folds of the meso–colon, meso-rectum, and even mesentery of the small intestines and disturbing the peritoneal folds of every organ in the pelvis. Then, too, the great tendency of such growths, especially cysts, to suppurate must be constantly borne in mind. An attempt to do more than drain an infected sac would be more than folly unless its walls were particularly well isolated and its enucleation complete. Where the mesentery has been dissected from the intestines, leaving large raw bowel areas unprotected, close adhesions between the cyst walls and the intestines will occur and often infected cysts will be draining into the bowel before the operation is attempted. In such cases it is best to establish drainage and make no attempt to disturb the sac. The main complication to be guarded against is hemorrhage. In fact the present technic is aimed at the early control of the ovarian and uterin vessels. The uterin artery is usually

the vessel that taxes the operator, and the technic now adopted has for its main object the early control of this vessel.

Hysterectomy as done for fibroid growths of the uterus, by cutting through the broad ligament opposite the growth and across the cervix, is undoubtedly a great advance in these cases. Unfortunately, though, such tumors develop during the active life of women and it will take a bold surgeon to adopt such radical measures in even the majority of cases. The combined vagino-abdominal operation will no doubt save the uterus and its adnexa in many instances, where hysterectomy is necessary to control hemorrhage if attempted by the abdominal route alone. The uterin vessel is seldom disturbed from its natural position by even very large growths, and can therefore be reached through a vaginal incision and controlled before the abdomen is opened. This can be done better through an upper and lateral opening in the vaginal fornix and should be grasped between the ureter and internal iliac if possible, to include the supply to all branches. If both broad ligaments are involved both uterin vessels should be controlled.

Double intraligamentary growths, especially if they have attained any size and can not be readily enucleated are undoubtedly best dealt with by hysterectomy as a routine measure. Hysterectomy is possibly the operation of choice when septic processes are present even though the vaginal vault can be readily opened. The anatomy of the ligament and its relation to the uterus show in many ways that the raw surfaces may not be drained if the uterus remains, therefore, if the mutilation of removing the growths makes pregnancy extremely doubtful it is best to sacrifice the uterus rather than trust to faulty drainage, when drainage is considered necessary. As a working rule it may be safely stated:

1. That in many cases where intraligamentary growths are suspected it will be best to first secure the uterin artery, or arteries, through the vaginal vault before opening the abdomen.

2. If cysts of considerable size are found occupying both broad ligaments and intimately connected with surrounding structures, hysterectomy as a routine measure will yield the most satisfactory results.

3. If sepsis is present—*e. g.*, badly adherent pus tubes, or an infected cyst sac, drainage is of utmost importance and is best

obtained per vaginam by removing the uterus unless very good reasons exist for retaining that organ.

4. Drainage is oftener indicated than in other pelvic conditions, owing to the extensive raw surfaces produced during the enucleation of the growth and the notable tendency of these growths to become infected.

Charity Hospital Notes.

(Specially reported for the JOURNAL.)

COMPLETE ABLATION OF THE SCAPULA.

BY S. P. DELAUP, M. D., ASSISTANT TO THE CHAIR OF GENITO URINARY AND RECTAL DISEASES, IN THE NEW ORLEANS POLYCLINIC.

The patient is a mulatto, aged 20. His family history points to tuberculosis. When admitted to the hospital he presented a suppurating sinus over the scapula. No microscopic examination was made, but clinically the sinus was plainly tuberculous in character. Under chloroform anesthesia the sinus was freely incised, and the scapula was found to be extensively involved. Accordingly ablation was determined upon. The usual Ollier's incision was made, and Ollier's subperiosteal method employed. Hemorrhage was very scant, no vessel of any size being injured. The case has progressed satisfactorily as regards the results of the operation. Flexion and extension of the forearm are perfect. The shoulder movements have not as yet been fully tested, bandages being constantly applied, but there is no indication that these movements will be impaired to any considerable extent. Suppuration has been troublesome, having persisted since date of operation. However, under the proper treatment the suppuration is at present subsiding, and the case is otherwise progressing well.

SALPINGITIS; CYSTIC OVARY; ADHERENT OMENTUM.

BY J. LEO BURTHE, M. D., VISITING SURGEON TO THE CHARITY HOSPITAL, NEW ORLEANS.

Mary W., a mulatto woman, aged 21, first came to the outdoor clinic in August, 1900. She gave a history of having had an abortion about two years before, which was followed by distressing pain in left iliac region, constipation and general pelvic discomfort. These latter symptoms subsided to some extent, and her condition remained such as not to cause any great inconvenience until a few days previous to the time she presented herself at the clinic. Leucorrhea, however, had persisted since the time of her first attack. She has not conceived since aborting. Vaginal examination revealed thickened tubes, left ovary enlarged and presence of a mass in the posterior cul-de-sac. Operation was proposed, but was at that time refused. She was not seen again until September, when she returned complaining of intense pain in lower abdomen; temperature 102; tubes, ovary and mass in posterior cul-de-sac were tender; in fact, patient presented all the symptoms of pelvic peritonitis. She was put to bed and acute symptoms treated. Ice-bag was applied; laxatives were administered to relieve constipation present; hot douches were ordered. Under this treatment all acute symptoms subsided in a week. She was prepared for operation, and on September 11, under chloroform anesthesia, through a supra-pubic median incision 2½ inches in length, the pelvic viscera were inspected. Upon introducing the fingers the omentum was immediately encountered, adherent to the right tube up to point of its junction with the uterus; thence the line of adhesion dipped down behind the uterus, and the lower extremity of the omentum was bound down to the bottom of Douglas' cul-de-sac. These adhesions were broken up, and, as the omental apron was observed to be unusually long, about two inches were amputated, hemorrhage being controlled by ligating in sections, instead of including the whole mass in one ligature. The left ovary was found enlarged, inflamed and cystic, its tube was also inflamed and thickened; accordingly both organs were removed. The stump of tube was secured with pedicle silk, and its lumen cauterized with pure carbolic acid. The right ovary and tube were uninvolved, although the tube showed evidence of having been slightly inflamed, most likely, during first attack. The pelvic

cavity was sponged, irrigated and incision closed with silkworm gut, no drain being used. Post-operative history has been uneventful with the exception of rise of temperature, which began at 3 P. M. of the day of operation and reached 102.4 deg. by noon the following day, gradually returning to normal within the following 48 hours. This febrile reaction was accompanied by restlessness, abdominal pain and intense headaches with some nausea, which conditions were met by application of ice-bag, administration of hot salin enemata, etc.; patient has been stimulated with strychnin and kept upon liquid diet. She had to be catheterized only once, immediately after operation; constipation, though slight, has persisted, necessitating laxatives. Nine days after operation patient was in good condition, temperature and pulse normal.

Resuscitation After Suffocation, Chloroform Poisoning, and Electric Shock.—Dr. J. Prus arrived at the theoretic conclusion that healthy human beings who were suddenly apparently killed by asphyxiation, electricity, chloroform, or other poisons, could be resuscitated by artificially imitating the conditions in which higher organisms are accustomed to live. These conditions can be simulated by artificial respiration and by an artificial circulation of blood. The former may be accomplished by the various well-known methods, while Prus found in his experiments that the circulation can be artificially stimulated most closely and most certainly by rhythmic pressure of the finger upon the exposed heart, for only in this way is it possible to evoke a systole and a diastole of the heart. By experiment, the author proved that this theory works in practice. He was able to resuscitate animals after suffocation after an apparent death of an hour by means of massage of the exposed heart, artificial respiration, and an infusion of normal salt solution into the femoral artery. Seventy per cent. of his experiments were successful. Of twenty-one experiments with animals in which the pulse and respiration were stopped by chloroform, the author successfully resuscitated sixteen, or seventy-six per cent. In some instances an hour had elapsed from the moment of death to the time of beginning the massage of the exposed heart.—*Wiener Med. Wochenschrift. New York Medical Journal.*

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

PATENT MEDICINES AND HONEST PHARMACY.

For several years New Orleans has been afflicted with an increasing number of so-called "cut-rate" drugstores, purporting to sell for less than all other drugstores, no matter what the commodity. The result has been that nearly all drugstores are now "cut-rate," and the self-respecting druggists who do not advertise their desire "to sell it for less" have suffered in their general trade as a consequence. Other druggists with small trade and some with large trade have arrived at the conclusion that the "cut-rate" business profits only the public and the manufacturer, and they have begun to combine with the object of recanting and again raising the price of patent medicines to a point where only the public can suffer. The larger and, therefore, more interested retail drugstores have held off and flagrantly advertise some few patent medicines and quack commodities, cosmetics, etc., at almost sacrificial prices—incidentally bidding, in one instance, for prescriptions which are to be filled at half price, whatever full price may mean.

The motive of the whole procedure is, of course, to practice upon the gullibility of the public to the very fullest extent. Under the lack of legal restriction, the patent medicine evil has grown to an extent which is really appalling. The very existence of some lesser literary (God save the mark) and medical periodic magazines is dependent upon the advertising of nostrums. The druggist calculates that from one-third to one-half of his stock room must be allotted to the constantly growing list of patent medicines demanded by the public. But the

beginning of the end is at hand. Now it is the quarrel of druggists with druggists over patent medicines. Soon it will be druggists with patent medicine concerns, for the evil has already borne fruit. Legitimate drug houses like Parke, Davis & Co., Wm. S. Merrill & Co. and others have opened branch establishments in this city and are doing excellent service among the physicians. Each day the more convenient methods of medicine administration urge upon the mind of the physician the advisability of doing his own dispensing. This, with the lack of interest on the part of the retail druggist in considering the doctor as a prime factor in his business, is beginning to produce a natural result. Messrs. Fairchild Bros. & Foster have been the first to secure legal conviction in a case of flagrant substitution, and we have a list of New Orleans druggists who have made themselves likewise amenable to the law, just because to them it is cheaper to be dishonest than to be honest in filling prescriptions. New Orleans has not yet evolved the prescription pharmacy, but the larger cities have met this demand, and New Orleans will some day follow suit. The man who is courageous enough to open a laboratory and prescription store, where nothing else is allowed except the honest dispensing of the written order for combined or pure drugs, would soon realize the respect and endorsement of intelligent practitioners of medicine. It would, besides this, establish a competition among the better druggists, and would help, through sheer, honest pharmacy, to bring about the much desired end of patent medicines, or, at any rate, would serve to hasten the demand, by the very victims of their use, for legislative action directed at the prevention of their sale.

So while the druggist, patent medicine, cosmetic and cheap prescription pharmacy, are being juggled in the advertising and other columns of the press, we, physicians, so much interested, may sit in the front row and watch the performance, with rather accurate speculation as to the outcome of it all.

THE NEW PRESIDENT OF TULANE.

The present generation of medical men in Louisiana is largely made up of graduates from the Medical Department of Tulane

and each year new recruits are joining the profession from the same institution. The president of Tulane in the years which have gone by has always filled a dignified function at the commencement exercises of the Medical Department at the time the fledgling medicos are presented to the public.

The new president has met the approval of all departments at the outset, and we feel that the spirit of his coming means a great deal for an amalgamated university. His public utterances have been dignified and sincere and fully pregnant with the appreciation of a large task before him.

We naturally feel a more distinctive pride in that part of the university which gave us the stamp of approval and, with the pride, feel that the occasion prompts the wish that in the new administration a closer bond may be drawn between the several parts of the institution.

Dr. Edwin Alderman is already versed in the craft of college making and he has left behind him in the University of North Carolina a monument to his energy and high purpose. This in itself proclaims the wisdom of his selection to his incumbent office. That he will fill the new and larger field of work we have no fear, but we feel that it becomes us to voice a large and growing medical profession in expressing the hope that as the departments of arts and sciences are developed for Tulane's good, the needs of the Medical Department may find adequate thought and attention as the methods of reform and improvement are administered.

We have received the September number of the *American Journal of Pharmacy*, containing an interesting article on "Atmospheric Ozone," by R. A. Hatcher, M. D. and H. V. Arny, Ph. D., Orleanites. It is based on experiments made at Covington, La. Aside from its technic and chemic value, the article is important as showing a good proportion of ozone in the Covington atmosphere, the latter being determined free from miasmatic emanations or other impurities deleterious to life.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

Anesthesia by Spinal Injection — The Bier-Corning Method.—Anesthesia by injection of cocain into the spinal canal, or, as it has been called improperly by some, medullary or spinal narcosis, has attracted widespread interest of late, and especially since the reading of Tuffier's paper on the subject at the International Medical Congress in Paris. Throughout Europe and in this country it has been carried out in a great variety of cases, and the method has been demonstrated to be of great value. We have thought it might be interesting at this time to refer to some of the important papers to be found in the recent medical journals. Marcus in the *New York Medical Record*, October 13, 1900, gives a brief resumé of the History and Development of the method. In this article he pretty clearly establishes by quotations from the works of Corning that to him should be given the first credit for this valuable discovery. While in Corning's first writings he made no attempt to enter the spinal canal, depending upon the interspinous veins to carry the medicament on in to the cauda, in his later work on "Pain" (1894), he describes the technic of a method which aimed to enter the canal; but, failing to let spinal fluid escape, he had no reliable means of telling with certainty whether he had actually emptied the solution into the canal. Consequently, his results not being uniform, his observations did not command the attention they deserved. For example he refers to the anesthesia as "amounting in certain localities, particularly in the lower third of the thigh and ankle, to a positive anesthesia." In the light of the definite and complete anesthetic results obtained by Bier, Tuffier and many others, this uncertainty of Corning's method explains why spinal anesthesia attracted little

attention and quickly fell into undeserved oblivion, until resurrected in 1899 by Bier, and by him placed on a firm basis.

Five years after Corning's last work Bier published his article in *Deutsche Zeitshrift für Chirurgie*, which was shortly after abstracted in this Department. (See the JOURNAL, September, 1899, p. 167.) It was immediately taken up by Seldowitch (see the JOURNAL, December, 1899, p. 346) and others in Germany, by Tuffier in Paris and others in this country. Tuffier's cases alone are now said to amount to over two hundred and fifty without a single serious mishap.

The first report of its use in obstetrics was made by Kreis in *Centralblatt für Gynecologie* July 14, 1900, followed by Doleris in France in *Semaine Médicale*, July 18, 1900, whilst Marx in this country has made the most extensive report of its use in labor, based on thirty successful cases, in the *Medical Record* of October 6, 1900, twenty-three being there reported in full. This is an extremely valuable contribution and the cases deserve to be studied in detail by any one who contemplates practising the method of spinal anesthesia for any purpose. Publications have also been made by Matas, Murphy, Riddle Goffe, Keen and many others, a list of whom is given in an admirable editorial in the *Medical News* of October 13, 1900. One of the best reviews of the subject is that published by Matas on Local Anesthesia in the last volume of Transactions of the Louisiana State Medical Society issued during the last month. It will well repay perusal by all who wish to get a clear and comprehensive acquaintance with the development of this whole subject of local anesthesia, including this spinal method. Much is being written about spinal anesthesia, and it will soon find its proper place in surgery; its indications, advantages and its limitations will soon be clearly defined. Moreover, further investigations will disclose, it is to be hoped, a method of extending its influence to the upper as well as to the lower extremities and perhaps, also to the head, though it is hard to understand how the successful application of the method to the higher centres of the brain will abolish pain without also doing away with consciousness, thus making the extremes of local and general anesthesia meet and placing cocain on the same danger plane as the general anesthetic. Medullary anesthesia is a "blocking" method in the same sense as is the infiltration of a nerve trunk, but car-

ried to the sensorium the method becomes real narcosis, and it remains to be seen whether it will have any advantages over the the present methods of general anesthesia. But even as thus far developed as a regional anesthetic method, it can hardly be said that the desiderata have been completely accomplished. Even Bier, after a year's experience with the method, cautions against its indiscriminate employment, and especially warns us against the use of such large doses as have been injected by some. Perhaps it may be shown, as Keen seems to believe from some of his experience, that eucain-Beta will be attended with less risk, on account of its less toxic character, and its surer sterilizability, but this Marx does not believe, since after trial he has found it unsatisfactory in its anesthetic effects. Perhaps, too, the coincident or subsequent use of hyoscin or nitroglycerin or some such drug may be of material assistance in warding off the disagreeable effects. Let us hope that our present high expectations may not be disappointed, but that the Bier-Corning method of anesthesia may increase in favor, growing by what it shall feed on—the prudent and well digested experience of the many workers now in the field. We have ourself had some very satisfactory experience with this method in several cases, which we shall publish in detail in the near future. We would be glad to have any reports of experience with the method in the hands of our readers. For the technic of the operation we would refer those seeking such information to Matas' article in the Transactions of the Louisiana State Medical Society, 1900, to Marx's paper in the reference here cited, to J. P. Murphy's Report in the *Chicago Clinic*, September, 1900.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans, La.

Medullary Narcosis During Labor.—Dr. S. Marx contributes to the *Medical Record* of October 6 a report of his application of spinal anesthesia by use of cocain, in twenty-three cases of labor. The article also deals at length with the technic, indications, and danger of the procedure, but as the subject has

been so generally discussed in recent publications it is hardly necessary to mention it here. Marx states that complications of a severe grade have never occurred in his work. Disagreeable features *frequently* occur; in fact, *it is a rule* to have them present, but fortunately their effect is transient, lasting from eight to twenty-four hours. These are frequent nausea, vomiting, headache, profuse perspiration, chilly sensations, temperature up to 102 to 103 deg. F., probably all due to a shock to the central nervous system or to disturbed intra spinal pressure. When severe they can be controlled by nitroglycerin combined with small doses of morphin. Later it was found that hydrobromate of hyoscin in 1-200 grain doses was very effective in controlling the annoying symptoms.

Uterin contractions go on regularly as if no narcotic had been used, the patient feeling no pain; and one is cognizant of the contractions only when the hand is placed on the abdomen. Reflex action of the abdominal muscle was found only when incomplete anesthesia existed, and was then accounted for by the presence of pain. When analgesia was complete there was no spontaneous bearing down, and the muscles were not voluntarily called into action. Only on command did the patient bear down and bring the abdominal muscles into play as powerfully as in an ordinary case. Explorations, versions, extractions, placental removals were done, not with quite as great ease as with chloroform, but with greater facility than in a non-narcotized woman. No greater disposition to hemorrhage than is found in ordinary cases was noted. A very useful point mentioned is, that in order to further the absolute success of operating, perfect quiet is necessary. Sight and hearing are unusually acute in these women and apprehension is ever present that they may suffer. The eyes of the patient should be snugly bound and the ears plugged with cotton.

The *New York Medical Journal* (July 28) devotes an editorial to this same subject in which the work of Dr. Oskar Kreis (*Centralblat für Gynäkologie*) is commented upon. Kreis had found that anesthesia lasted sufficient time to admit of the painless performance of any obstetric operation, or ordinarily the completion of spontaneous labor. Kreis points out that with excitable women, those who, although feeling no pain, can not restrain their outcries or lie still, but give way to apprehension at each movement of the hand or forceps, a general anesthetic

is preferred. It is quite probable, says the editorial, that the only great advantage of cocain analgesia in obstetrics will be found in its enabling the physician to dispense with an anesthetic.

Scope of Immediate Mechanic Dilatation in Obstetric Practice.—*Obstetrics* for August contains an extract of an article contributed (*Ann. di Ostet.*) by Professor Bossi, of the University of Novara, in which the advantages and methods of mechanic dilitation in obstetric practice are fully dealt with.

Bossi's conclusions would indicate that the method has been quite successful and free from untoward effects in his experience, but the editor of *Obstetrics* takes exceptions to some of the conclusions, especially the statement that "not over fifteen or twenty minutes are required for complete dilitation in the most obstinate cases," and contributes an editorial upon the subject. He considers such a statement entirely misleading to those dependent upon the experience of others for their opinions. Perhaps in the majority of cases complete dilitation can be secured without laceration in from 15 to 20 minutes, but there are many cases in which such efforts would result disastrously. It is probably the experience of most obstetricians that rapid dilatation proves more difficult than was primarily expected. The thin and soft lips of the cervix seem most easy to stretch, but after the first inch or two of dilatation the parts begin to thicken and the operation grows more tedious; moreover, complete dilatation involves something more than the cervix. It includes the lower segment of the uterus as far as Baadl's ring, and it often proves necessary to apply considerable traction on the breech or with forceps to the head to withdraw the child after full dilatation is supposed to be secured. In primiparæ it may take a full hour to get complete delivery dilatation without causing cervical laceration, whether the hands, Barnes' bag, or Bossi's relative dilators are used. And in all cases if the cervix and parts just above it could be seen with the eye, the inner surface will be found extensively ecchymotic. No hand or instrument can rival Barnes' bag in the evenness and relative gentleness of forced dilitation, yet a Barnes' bag will often lacerate the cervix if distended in all cases at the speed given by Prof. Bossi.

Suspension of the Uterus on the Round Ligaments.—Dr. Carl Beck contributes to the September number of the *American*

Journal of Obstetrics the description of a technic which he has devised for suspending the uterus on the round ligaments. The main features of this method consist in opening the abdomen in the linea alba by a small incision, seizing the fundus uteri by traction forceps, and pulling it outside of the abdominal cavity. This feature is facilitated by the Trendelenburg position. The round ligament of one side is there detected and freed to the extent of nearly three inches, the isolation beginning near its uterin attachment, superficial incisions along both sides of the ligament permit the introduction of a grooved director, by means of which the peritoneum can be stripped away bluntly, so that no hemorrhage occurs. The bared ligament is then held up by an aneurism needle and pulled out from the abdomen to such an extent that the peritoneal wound margins can be united underneath. Six to seven catgut sutures suffice for the purpose. The ligament now rides on the peritoneum. To strengthen this peritoneal anchorage, fascia and muscle are also united underneath, while the ligament is suspended. One additional suture through the round ligament usully suffices for fastening it securely.

The remaining portion of the wound is dealt with in the usual manner. The margins of the integument are brought together by subcutaneous catgut sutures. Two relaxation sutures consisting of iodoform silk are applied through the skin, three quarters of an inch distant from the wound margin so that there is no direct contact with the wound line.

For prolapsus uteri, suspension on one ligament is often sufficient. Lateral position of the uterus can not be avoided by unilateral suspension, but in practice this proves harmless. In *retroversion*, fixation of both ligaments is of course necessary. This is accomplished by treating both ligaments alike.

If much tension is to be overcome, incise the internal margins of the rectus muscle on both sides as in Beck's operation for inguinal hernia, liberating a few muscular fibres, hanging the ligament over them and uniting the flaps. Beck claims for the operation that it has the great advantage of suspending the uterus free and movable in a perfectly normal position which permits of such free motion that there is no interference either with the bladder or with the rectum, and consequently there is no obstacle to pregnancy.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Gall Stones and Hydatid Cyst of the Liver.—The differential diagnosis is often difficult, the more so that both may coexist from close relation—*i. e.*, a cyst by pressure may impede the flow of bile, and as a result also of unusual desquamation in the biliary ducts may cause biliary calculi. A case is presented as an example, viz.: Repeated attacks of excruciating colicky pain in the right hypochondrium radiating to the right shoulder, followed by jaundice and by extra cardiac murmur, the latter being usually present in hepatic colic. But, there was a high temperature at the time of the paroxysms, and yet between the paroxysms no other sign of angiocolitis. The stools were not discolored, the spleen was normal, and the pain in the gall-bladder area between the paroxysms did not exist, all signs, chiefly the latter, *unusually* referable to biliary calculi. It was then discovered that the stools contained hydatid shreds and débris which were recognized by microscopic examination.

There had been ulceration and perforation of the biliary ducts and rupture of an hydatid cyst into the ducts or gall-bladder, the passage of the hydatids causing pains and paroxysms like biliary calculi do, the paroxysms occurring at intervals, varying from severals days to several weeks. The fever is explained by the resorption of infectious elements as a result of the contraction of the ducts and gall-bladder to expel the hydatids. Cases of periodic tertian fever due to this cause were reported by Trousseau. In this particular case, presented here, the liver at first large became reduced in size as if the cyst had emptied itself entirely, and the general condition being good, no treatment was adopted, as the latest paroxysm might be the final. Referring to treatment in cases of hydatid cyst, chiefly as regards the danger of rupture, or according to its location, the latter might be either favorable or serious, even fatal (pleura, peritoneum, vena cava, etc.), it is important to *empty entirely* the cyst if aspiration is at all made, since a half distended cyst will more easily be caught, squeezed and ulcerated into organs and

structures in its vicinity.—*Hôpital de la Charité. Clinique de M. le Professeur Potain.—Jour. de Med. et de Chirurgie Prat.*, September 10, 1900.

Quinin in Malignant New Growths.—Dr. Jaboulay of Lyon has found that in the form of a 10 per cent. solution which is not caustic for either skin or mucosa and acts only as an irritant upon denuded surfaces, quinin applied to visible and accessible epitheliomata caused arrest of growth and invasion, retrogressive changes and disappearance of odor and pain. He was thus led to believe that quinin destroyed the protozoa which, according to his views, produced the epithelial type of malignant new growths. He found that quinin given internally by hypodermics or by the mouth brought about similar favorable changes in non ulcerated and deeper malignant new growths, and he mentions as examples several cases of schirrous carcinoma, sarcoma, etc. He was thus led to believe that most if not all true tumors are produced by protozoa, the special types of which might account for degrees in malignancy, and thus he gives quinin also in cases of varicose lipomatous, fibromatous and myxomatous growths. In fact he gives quinin systematically to all his cases of more or less malignant new growths and considers that those cases should be treated like malarial and syphilitic diseases, in other words, for a long period, partially in view of possible recurrence elsewhere or generalization. The protozoa of malignant new-growths and of malarial poisoning equally tend to recurrence and dissemination through the system by means of the lymph-channel and the blood under unforeseen forms. Jaboulay thinks that no operative measure should be adopted before testing first the preventive action of quinin. Might not quinin prevent the formation of malignant new-growths? Figures show that in malarial districts where quinin is commonly used and taken in large doses malignant new-growths are not so common as elsewhere. Jaboulay uses quinin hydrochlorate; when hypodermically, he injects it at a place remote from the tumor, never in the tumor itself. The hypodermic is painful, but absorption is more secure; he generally gives quinin by the mouth. The dose he gives is from 50 centigrams (gr. viii) to 2 grams (gr. xxx) a day, dependent upon the individual tolerance of the subject. Should the patient

lose flesh, quinin must be discontinued. Some salt of quinin other than the hydrochlorate might probably be found that will prove to be a less toxic and more active succedaneum.—*Ib.*

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

The Action of Digitalis Upon the Kidney.—Porter recently read a paper, reported in the *Medical Record* of May 12, 1900, on this topic. His conclusions are that (1) the chemic composition of digitalis is complex, some of its active principles antagonizing others; (2) the various preparations of digitalis differ widely in their composition and action; (3) the so-called cumulative action of the digitalis is due to its contracting the arterioles and shutting off nutrition; (4) it is both a useful and a dangerous remedy, and has a very limited range of usefulness; (5) it is of use only in lesions of the mitral valve, and then only for a short time, and should be discontinued as soon as these have been overcome; (7) it is of value as a diuretic only when there are low arterial tension and engorgement of the kidney; (8) digitalis increases the excretory action of the normal kidney and impairs its nutritive activity.—*The Therapeutic Gazette.*

Coffee Intoxication.—Combemale in *Echo Medical du Nord*, March 11, 1900, records the case of a man who was admitted under his care on account of giddiness, which came on suddenly in the street. The case was taken by the police for one of intoxication. On admission he was noticed to be extremely thin, and suffered from vague pains in the limbs and loins, intense headache, generally worse at night, and most marked in the temporal regions, which he described as a heavy cap pressing on his head. It prevented his sleeping more than two hours or so in a night. He dreamed considerably, and stated that he always saw grotesque animals passing before him. Pressure over the calves elicited considerable pain of a muscular character. The reflexes appeared to be normal, and there was no alteration of sensibility. There was no tremor; the gait did not present any

marked characters other than a slight heaviness. There was no Romberg's sign. The lungs showed slight degree of emphysema. There were no valvular lesions of the heart nor alteration of rhythm. The man was by trade a rag gatherer.

This description corresponds with that given some years ago by Guelliot, namely, emaciation, paleness of the face, some tremor of the lips, muscular pains and vertigo—as occurring in cases of chronic caffeinism. In this case the patient was in the habit of going from house to house, where the contents of the coffee-pot were reserved for him, which he was in the habit of consuming in large quantities.

The literature on this subject is not extensive—in fact, the condition has not been widely recognized; but Combemale is able to quote references to the condition, especially those of Viaud (*Tribune Médicale*, 1897). He finds that intense vertigo, which may be mistaken for Ménière's disease, and very marked bradycardia, are characteristic of chronic caffeinism. There are also ringing in the ears, a sensation of falling and other evidences of alteration in the central nervous system. Mendel is also quoted by the writer as noticing general weakness, distaste for work, mental depression, insomnia, tremor, palpitation, coldness of the extremities, symptoms of dyspepsia, obstinate constipation, as present in this condition. The prognosis seems to be good, as, on avoiding the use of coffee, these various manifestations of intoxication rapidly disappear, though recurrence is common.—*British Medical Journal—The Therapeutic Gazette.*

Bromide of Rubidium in Epilepsy.—Laufenauer recommends the following formula in the treatment of epilepsy and claims that the bromide of rubidium is not so depressing as the bromide of sodium or the bromide of potassium:

℞ Double bromide of rubidium and ammonium.....90 grains.
Distilled water..... 3 ounces.
Syrup of lemon..... 6 drachms.

A teaspoonful to a dessertspoonful of this mixture to be given three or four times a day.

—*Journal de Médecine de Paris.*

Whooping Cough.—Dr. J. A. Reagan (*Char. Med. Jour.*) uses the following prescription:

℞ Alum powd..... 1 oz.
Strained honey..... 3 fl. oz.

Mix thoroughly. One teaspoonful every hour when awake, whether coughing or not.

Chronic Malaria.—The following prescription is taken from *Merck's Archives:*

℞ Quinin sulphate ..... 1 dr.
Mass. iron carbonate ..... 1 dr.
Arsenious acid ..... 1 grn.

Make into 20 capsules and give one three times a day.

—Wilson, *Therapeutic Digest.*

Effervescent Quinin Mixture—

℞ Quinin sulphate ..... 4 dr.
Citric acid ..... 10 dr.
Simple syrup, } ..... 1 fl. dr.
Orange peel syrup, of each, }
Distilled water, to make ..... 20 fl. dr.

Add 10 or more drops to about an ounce and a half of water in which 5 grains of sodium bicarbonate have previously been dissolved, and drink while effervescing.

—*Klin. Therap. Wochenschr.*

Malarial Fever—

℞ Quinin hydrochlorate ..... 2 dr.
Dilute hydrochloric acid ..... 4 fl. dr.
Dilute hydrobromic acid ..... 1 fl. oz.
Syrup lemon ..... 4 fl. oz.
Water ..... 1 fl. oz.

Teaspoonful three times a day.

—Eshner, *Philadelphia Polyclinic.*

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King, New Orleans.

[Further resumé of subjects discussed in the Section of Laryngology and Rhinology at the Thirteenth International Congress of Medicine, Paris, August 2, 1900.]

Spasmodic Rhinitis.—*By Dr. Alexander Jacobson, of St. Petersburg.*—Spasmodic rhinitis, according to its etiology and course, presents several varieties and forms. These different forms are often confused for the reason that they are not sufficiently studied and differentiated. It is necessary, therefore, to consider hay fever as a particular variety, since that disease is the most studied and is known to have a periodic character and

a special etiology established by experimental research. The term "Hay-fever" should not be applied to the other forms of spasmodic rhinitis due to other causes.

Many cases of spasmodic rhinitis are due to vaso-motor paralysis, the "Coryza Vaso-motoria" of Moritz Schmidt. Certain other forms are due to the influence of toxins, and may be designated as "toxirhinitis." These cases may be induced by toxication or auto-intoxications, run an acute course, and are complicated with gastro-intestinal and cutaneous manifestations. It may occur in persons of excellent health and without predisposition, is self limited and has no tendency to recur. Nasal hydrorrhea is the only form known to be due to vaso-motor disturbance. Nasal hydrorrhea due to internal causes has no local manifestations excepting abundant nasal secretion. The mucous membrane is neither tumified nor injected.

Pathology and Diagnosis of Vocal Nodules.—*By Prof. O. Chiari, Vienna.*—Various lesions of the larynx are described as vocal nodules. Chiari describes the condition as follows:

The nodules are rounded and somewhat elongated; are situated on the free border of the true vocal cords, usually at the junction of the anterior and middle thirds; their situation is nearly always symmetric. The color is white tinged with yellow or red; they are opaque, about the size of a pin head, sessile, and with usually a smooth surface.

These special characters distinguish it clearly from fibromata, cysts, papillomata, and other neoplasms, as also from tuberculous and syphilitic nodules. They never ulcerate and sometimes disappear spontaneously. Chiari found from one half to one per cent among one hundred cases of laryngeal affections, and twice as frequent in woman as in men. They are especially frequent in singers and relatively common in children.

The principal cause are chronic and acute catarrh of the larynx, over exercise of the voice, and defective methods of singing.

Mucous glands are found very exceptionally in the structure of these nodules. They are considered as formed by hyperplasia of the epithelium and superficial fibrous layers of the vocal cords.

Vocal Nodules.—*By Prof. Hermann Krause, Berlin.*—Vocal nodules are small globular bodies, varying in volume from the size of a pin head to a grain of barley, situated on the free

border of the vocal cord. They are usually caused by faulty emission of the voice during singing, but not while speaking. Characterized anatomically by fibrous tissue with cystic contents and thick pachydermic covering, which incloses the fibrous nucleus and finally produces an atrophy of it. These nodules cause an alteration of the singing voice in certain points of the scale by preventing the cords from approximating properly and interfering with the elasticity of the cords.

Treatment consists in bringing about an atrophy of the nodules by rest of the voice and strict forbearance from singing. When this does not suffice and a quicker result is desired, removal by surgical means is indicated.

Treatment of Vocal Nodules.—*By Dr. Capert, of Brussels.* The treatment of vocal nodules may be hygienic, medicinal, operative. Several authors reported cases cured by enforced silence alone, but this author believes that rest can only cure the existing laryngitis, and does not believe that it has any effect on the nodules themselves. After mentioning the various methods of medicinal treatment by means of insufflations of astringents and antiseptics and applications of nitrate of silver and other caustics, he condemns them all as unsatisfactory if not dangerous, and advocates removal by surgical means or with the galvano-cautery.

The Schmidt or Juras laryngeal forceps are recommended for removal of these growths, and the importance of removing the entire nodule is insisted upon. After the operation silence is enjoined for a few days and singing prohibited for one month. To prevent recurrence an absolute change of the singing method and of the teacher, if necessary, is indicated. Sojourn at a watering place is beneficial.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

Formalin in Ophthalmology.—Formalin is the name of a 40 per cent. solution of formaldehyde gas in water. It is a colorless, volatil fluid, non-poisonous, of a pungent odor, and

is miscible with water in all proportions. It is superior, in its germicidal action, to corrosive sublimate in solutions of a strength which can be well tolerated. When used pure it is an escharotic, but when in suitable dilution it is one of the most powerful antiseptics known. In fact, it is said to be the most powerful non-toxic antiseptic and bactericide at our disposal. Its value in this line may be more evident when we consider that when used in a solution as weak as 1 to 100,000 it prevents the development of bacteria, and a solution of a strength of 1 to 75,000 is germicidal.

Its powerful bactericidal properties were pointed out by Loew in 1886, and further work was done upon the compound by Aronson, Berlioz, and by Trillat of the Pasteur Institute. The observations of Trillat were published in 1891. In 1894 Pattevin found that when formalin was added to cultures of bacteria their growth was arrested. Cohn observed that formalin had the power of killing bacteria both in the vegetative and spore stage—an observation confirmed by Alleger and others.

"Formalin is a safer agent, by far, than corrosive sublimate, because it is not actively poisonous.

"In ophthalmology the strength of the solution which is preferable for general antiseptic use is 1 to 2,000. This strength is very useful in muco-purulent and follicular inflammations of the conjunctiva. For purulent conjunctivitis (ophthalmia neonatorum, etc.), a stronger solution may be used at first until the amount of discharge begins to decrease. In blennorrhea of the lachrymal sac the use of formalin has proven more satisfactory in my hands than has the use of silver nitrate solution. In both purulent conjunctivitis, except for the primary application, and blennorrhea of the lachrymal sac I have for some time used formalin in preference to silver nitrate. In cases of infected ulcerations or abrasions of the cornea the wound may be touched once a day with a solution as strong as 1 to 500 or 1 to 200.

"All solutions of a strength under 1 to 4,000 cause smarting, but this is less intense and of short duration as compared to that caused by silver nitrate. In a solution of 1 to 2,000 or 1 to 3,000 formalin is used to disinfect the skin of the lids and the eyelashes prior to operation. For cleansing the conjunctiva prior to operation a solution of 1 to 4,000 is preferable."—Lauder *in Cleveland Medical Gazette*, September, 1900.

Indications for Enucleation of an Eyeball.—Albert E. Bulson, in the *Fort Wayne Medical Journal* for May, gives the following rules in regard to enucleation:

First, enucleation should be performed if the eyeball has been so injured as to make recovery of sight almost hopeless, and the onset of iridocyclitis almost certain. Second, enucleation should also be performed in the same case where iridocyclitis has already set up in the injured eye. Enucleation should be performed in a case of iridocyclitis, where a foreign body which can not be safely extracted is present in the eye, even though the vision is fairly good; because we known that here the danger of sympathetic ophthalmitis amounts almost to a certainty. Third, enucleation should be performed in a case of iridocyclitis, traumatic or idiopathic, where vision is lost, especially if the eye is tender on pressure; for here the ball is useless and disfiguring, and apt to be a source of danger to its fellow. Fourth, enucleation should be performed in a case of phthisis bulbi, even of old standing, where there is shrinking pain or pressure, for the eyeball here as in the previous instance is useless and apt to be a source of danger to its fellow eye. Fifth, enucleation should be performed in a case where the sympathizing eye is already affected, provided vision in the exciting eye be lost, and hopes of its recovery slight, if any. Sixth, enucleation should be performed in a case of sympathetic irritation, if the sight of the exciting eye is very defective and the neurosis very persistent.

On the other hand enucleation should not be performed in a case of an injured eye if its sight is fairly good and yet no signs of inflammation are present, unless it contains a foreign body which can not be extracted. Second, the exciting eye should not be enucleated if sympathetic ophthalmitis has already appeared, provided the vision of the exciting eye be fairly good. The reason for this is that the inflammatory process in the sympathizing eye is sometimes *not* arrested by the enucleation of the exciting eye, and where enucleation is not performed the exciting eye sometimes in the end turns out to be the organ with the better vision.—*The Charlotte Medical Journal.*

Operative Treatment of High Myopia.—Cross (*Trans. of of the Oph. Soc. of the United Kingdom, 1900*), in a paper read before the Ophthalmological Society, considered that the opera-

tion for high myopia had gone past the experimental stage and that it should now rank as a thoroughly recognized surgical procedure. He admits that there is a risk of detachment of the retina, but thinks that opinion is gaining ground that the danger of its occurrence as a direct result of the operation has been exaggerated. Cross has operated on forty-eight cases and not in a single one has he had any cause for regret.—*Brooklyn Medical Journal.*

Miscellaneous.

International Medical Congress, Paris, August, 1900. Section on Genito-Urinary Surgery.—*Conservative Operation for Renal Retention.*—Küster, of Marburg, advocates the following conservative procedures in cases of renal retention:

A. Fixation of the dislocated kidney (Guyon), either alone or combined with the detachment of the ureter or some plastic operation.

B. Anastomosis (1) of the ureters, (2) of pelvis and ureter, (3) pelvis and bladder.

C. Plastic operations with or without resection of the ureters:

1. Pyeloptychy (I. Israel). 2. Incision of valves and transverse suturing (Fenger). 3. Resection of the constricted ureter; preferably oblique resection. 4. Pyeloneostomy, methods of Trendelenburg and Küster.

D. Partial resection of kidney. 1. Resection of pelvis and suturing (Albarran). 2. Cuneiform resection of the substance of the kidney in hydronephrosis with horseshoe-shaped kidney.

Fenger reported five cases in which no relapse occurred after operation:

1. Valve formation. Transpelvic operation. No relapse six years later.

2. Stricture at upper end of ureter. Extra pelvic operation. No relapse six years later.

3. Valve formation of lower branch of ureter. Extrapelvic operation, bisection of kidney, division of partition. No relapse after three years.

4. Excision of valve in ureter by a plastic operation (Fenger). No relapse after three years.

5. Stone in upper end of ureter removed. One year later plastic operation performed by another surgeon. Six months later, complete occlusion of ureter at site of second operation. Plastic operation (Fenger). No relapse one year later.

He also recites two cases where no result was obtained, and nephrectomy had to be performed.

Bazy (Paris) dwells on the indications for conservative methods. He believes they are indicated only when the kidney can still perform its functions and is not a source of danger in itself. In simple hydronephrosis the indication is precise; it is less so in infected hydronephrosis; but it is absolute when there is but one kidney, no matter what its condition. Infection of the ureter and pelvis is not a contraindication. Abscess of the kidney is an absolute contraindication to any anaplastic operation.

Second Subject.—*Value of Surgical Interference in Vesical Tuberculosis.*—Syl. Saxtorph (Copenhagen): Operation is out of the question in miliary vesical tuberculosis. It is only in isolated chronic urinary or urogenital tuberculosis that operation can be resorted to. Since the bladder is never primarily infected, the cause or source of the infection must be removed (nephrectomy, resection of ureter, etc.,). Once this is done, tuberculosis of the bladder may heal spontaneously. If not, a surgical operation is in order. Suprapubic route. Excision of diseased tissue or curettage. Thermocautery. Suturing or drainage according to case. When the cause of the infection can not be removed, palliative measures are indicated.

Value of Surgical Interference in Urogenital Tuberculosis.—Albert Hogge (Cork) winds up his report with the conclusions that follow: In tuberculosis of the prostate, vas deferens, seminal vesicle, epididymis or testicle the indication for an operation is clear-cut and admitted by all, provided there is an abscess or fistula. The operative methods may vary; but we must operate in these cases with very rare exceptions, such, for instance, as result from the general condition, because an operation is assuredly of more curative value and less risky to the patient, than the expectant or the therapeutic treatment. But in view of our present knowledge of the subject, the ques-

tion arises, must we operate only in such cases? While surgeons differ materially on this question, the fact remains that the very few cases of total extirpation of the genital tract so far reported, show such favorable results as to justify a more frequent practice of this operative procedure.

Value of Surgical Interference in Renal Tuberculosis.—Pousson (Bordeaux) presents very interesting statistics.

Immediate results.—Of 600 cases, mortality, 21.33 per cent.; nephrotomy, 20.8 per cent.; nephrectomy, 21.47 per cent. Statistics of certain surgeons: Nephrotomy, 18.51 per cent.; nephrectomy, 6.54 per cent.

Distant results—comparing the second operation we find mortality during year following nephrectomy, 12.54 per cent.; nephrotomy, 61.70 per cent.

THIRD SUBJECT.—*Remote Results of Operations for Hypertrophy of the Prostate.*—Von Frisch (Vienna) believes that only surprapubic perineal and lateral prostatectomies and the Bottini operation give permanent results. All the operations have yielded some very satisfactory results, but they are uncertain. So far there is no precise method of operation which gives us the assurance of permanent success.

In connection with the subject Leguen (Paris) considers three kinds of operations:

A. Castration—Following the operation the patient feels better, but there is no atrophy of the prostate, only a slight diminution in size. There is no cure, merely an improvement in the symptoms, which does not justify the sacrifice of the testis.

B. Cystotomy—This operation substitutes one infirmity for another. Incontinence is the rule, and the bladder does not empty itself. It should therefore be used only in exceptional cases.

C. Prostatectomies—This is the most rational line of treatment. Bottini's operation comes under this head. We can not judge of its permanent effect owing to lack of sufficient evidence. It is a blind operation. The multiple relapses in some cases show how rapidly the new-made groove closes.

Partial prostatectomy gives good results in partial hypertrophy.

Total prostatectomy alone can remedy the discomfots of hypertrophy. Although the present data do not permit us to

estimate its just value, they are sufficient to show that perineal prostatectomy, practiced early in the disease, will some day become the operation of choice.

FOURTH SUBJECT.—*Remote Results of Sanguinary Interventions in Stricture of the Urethra.*—Heresco (Bucarest) arrives at the following conclusions:

1. No sanguinary method known at present, except resection of the urethra in certain determined cases, can definitely cure urethrostenosis.

2. Internal urethrotomy is not a definite operation for gonorrheal stricture when there is more or less sclerosis of the whole urethra; it only facilitates dilatation.

Recurrence takes place in all internal urethrotomies where dilatation is not practiced.

3. The period of recurrence varies from a few weeks to many years (thirty years in one case) and depends upon the nature of the stricture and the manner in which dilatation was carried on.

4. External urethrotomy does not cure any more than internal urethrotomy.

Recurrence takes place just as in internal urethrotomy; the period of recurrence varies in like manner.

When the perineum presents fistulæ, indurations and callosities, external urethrotomy is of greater advantage because it liberates the perineum externally.

5. Resection of the urethra can cure in certain determined conditions. These conditions are rare.

6. All sanguinary interventions must be followed by a long continued treatment by dilatation.

Albarran (Paris) puts his conclusions under three heads:

(*A*) *Uncomplicated Inflammatory Stricture.*—In regard to frequency of recurrence the different methods can be classed as follows: Electrolysis, progressive dilatation, internal urethrotomy, external urethrotomy, and resection and autoplastic operations.

(*a*) Electrolysis practiced at one sitting is followed by recurrence. The period of recurrence depends directly on how long after dilatation is continued. The prolonged method of electrolysis appears to give better remote results.

(*b*) Progressive dilatation must be practiced systematically to No. 60 Béniqué. The normal tone of the canal must be restored at

the same time. Except in light cases the results attained can only be made permanent by occasional dilatation.

(*c*) Internal urethrotomy seems to give better results when multiple incisions are made. For the results to be permanent dilatation must be employed and the urethra be restored to its normal condition as in progressive dilatation. Recurrence is as liable to take place as in the foregoing method.

(*d*) External urethrotomy is a procedure far superior to all the above methods but is only applicable to limited strictures. It has cured cases of itself without the aid of further treatment. Such instances are rare, the result obtained by the operation must be maintained by the systematic use of sounds.

(*e*) Resection of the urethra gives results equal if not superior to those following external without any. When the stricture is completely extirpated a cure can be expected even without further treatment.

(*B*) *Inflammatory Strictures Complicated by Tumors and Urinary Fistula.*—External urethrotomy and partial or complete resection of the urethra yield the best remote results.

Autoplastic operations have only been performed in a few special cases which cannot be compared with those for which the other operations were resorted to.

(*C*) *Traumatic Stricture.*—Dilatation and internal urethrotomy are quickly followed by recurrence. External urethrotmy gives better results but may also be followed by recurrence. Restriction of the urethra is the best operation; it is even better in traumatic than in inflammatory strictures. It can cure without the aid of further treatment.

Tuberculosis and Some Medications.—At the *International Medical Congress of Electrology and Radiology* held in Paris, from July 27 to August 1, 1900, Dr. Rivière, of Paris, read a paper from which he has drawn the following conclusions:

The high frequency currents and, in particular, the *mono or bi-polar* effluvations of Oudin's *resonator* or of d'Arsonval's new *transformer* cure pulmonary and localized tuberculosis. The cases mentioned of rapid cure were of tuberculous sores and fistular tuberculous glands. He has also attained good results in cases of tuberculosis, of the bones, of white swellings and Pott's disease. Repeated applications of these currents stop the development of microbes and lessen the virulence of their

toxins. Whilst the above currents have a tonic action upon the human body, they kill the microbe by means of their *actinic* rays. It is likewise probable that, under the influence of electric baths, the wholesome effects of the phagocytes are enhanced. In such conditions, therefore, it is obvious that the diseased organism regains strength and, with the help of the phagocytes, ultimately overcomes the enemy.

It only then remains to place the patient in the best possible conditions of hygiene and feeding so as to check the recurrence of the disease.—*Imp. de l'Institut de Bibliographie.*

Louisiana State Medical Society Notes.

All Members of the Society are requested and urged to send to the Journal any items of interest. This refers to personal items: honors conferred, marriages, deaths, removals, partnerships, success in practice, etc., in all of which the Journal and the members at large are interested.

The Recording Secretary, Dr. H. B. Gessner, 127 Baronne street, New Orleans, requests members who have failed to receive their copies of the 1900 transactions (with Constitution and By-Laws) to communicate with him. In some instances this failure is due to doubtful membership of the individuals, their names being on the Secretary's list and not on the Treasurer's, or vice versa.

Remember that by paying your dues for the current year you will receive the Journal free of cost.

The Chairmen of Sections are earnestly requested to consider the work of the coming year.

The next meeting of the Louisiana State Medical Society will be held in New Orleans, April 18, 19, 20, 1901.

Personal.—Dr. W. Glendower Owen, of White Castle, late president of the Society, was selected to represent the Louisiana State Board of Health at the meeting of the Mississippi Valley Medical Association, held at Ashville early in October.

Obituary.—Dr. Thos. J. Woolf, of New Iberia, died at Denver, Colorado, on October 1. Dr. Woolf was always an enthusiastic member of the Society and could be depended upon at every meeting. His humor and aptness in address made him ever a welcome speaker.

Dr. Woolf was for some time in New Orleans, where he made many friends.

The remains were brought to New Iberia for interment.

Announcement of Chairmen of Sections for 1901, Meeting.—*Section on Surgery*, Dr. E. D. Martin, 115 Chartres St. Subject for general discussion: Treatment of fractures of the long bones of the upper and lower extremities.

(Other Chairmen will please send titles of subjects to the Journal).

Medical News Items.

The Pan-American Medical Congress will hold its third meeting in Havana, December 26, 27, 28 and 29, 1900. A circular has been issued by Dr. Thomas V. Coronado, the Secretary General, giving the detail of the organization of the Congress, and both urging and inviting the profession of the United States to attend the coming meeting.

It is to be hoped that the Congress will be well attended, as this is not the first attempt in organizing the third meeting.

All those who are desirous of attending or who wish to read papers should address the secretary, at "Prado 105, Havana, Cuba."

The officers of the Executive Committee are always residents of the country in which the Congress is to be held, and those of the present scheme of the organization are: President, Dr. Juan Santos Fernandez; vice president, Dr. Gustavo Lopez; Treasurer, Dr. Enrique Acosta; committee members, Drs. Vincente B. Valdes, Jose Torralbos, Eduardo F. Pla and the secretary.

The program giving the place of meeting and detailed arrangement of work is not yet issued.

The Western Surgical and Gynecological Association will meet in Minneapolis, Minn., December 27-28, 1900.

An Isolation Hospital for New Orleans is under consideration by the City Council. An excellent plan has been drawn and the detail worked out by Dr. S. L. Théard, secretary of the City Board of Health. This was presented to the City Council recently with the endorsement of the Orleans Parish Medical Society, the City and State Boards of Health. Although New Orleans is practically free of small-pox or other diseases of the contagious class, yet the urgent need of such an institution in the recent past demands the consideration and the action of the municipal authorities.

New Home for the J. B. Lippincott Company.—This well-known publishing house has acquired a new location on East Washington Square in Philadelphia. A number of old dwelling houses, in an historic locality marked as the site of the old Walnut Street prison, etc., are to be demolished to make place for a modern structure suitable to the needs of this progressive concern.

The Phagocyte is the title of a periodic to be issued during the session of the Medical Department of Tulane University. The editors are to be selected by the class and the publication is to be devoted to matters pertaining to the school and to contain medical articles of local interestt.

A New Board of Health for Monroe, La., was elected recently, consisting of Drs. C. W. Hilton, O. H. Gladden, M. A. McHenry and Messrs. W. L. Jones and E. T. Lamkin. An ordinance was submitted by the mayor and was passed, giving broad authority to the Board of Health in the matter of sanitation.

The American Association of Obstetricians and Gynecologists met in Louisville in September. Cleveland was selected as the next meeting place. The officers for 1900-1901 are as follows: Dr. W. E. B. Davis, Birmingham, Ala., president; Dr. Edwin Walker, Evansville, Ind., first vice president; Dr. A. Goldspohn, Chicago, second vice president: Dr. Wm. W. Potter, Buffalo, secretary, and Dr. Xavier O. Warder, Pittsburgh, treasurer.

The Southern Surgical and Gynecological Association will meet in Atlanta November 13, 14 and 15 under the presidency of Dr. A. M. Cartledge, of Louisville. Prospects are splendid for a successful session. Members of the medical profession are cordially invited to attend.

An International Society for Sanitary and Moral Prophylaxis is to be organized as the result of the Brussels Conference for the Prophylaxis of Syphilis, etc., held last year. The new society is to have its meeting place at Brussels, from which place a journal is to issue to the members of the society. The next meeting of the society will take place in 1902.

The Medical Society of the Missouri Valley held its annual meeting at Council Bluffs, Iowa. Three days were devoted to the medical sessions and a delectable banquet followed. Dr. V. L. Treyner, of Council Bluff, is president for the coming year, with Dr. Chas. Wood Fassett, of St. Joseph, Mo., secretary. The next meeting will be held in March, 1901, at Omaha.

Messrs. Battle & Co., of St. Louis, have begun a series of plates, illustrative of surgical lesions, which are to be issued at intervals in connection with a pamphlet of clinic articles advertising their several laboratory products.

The Orleans Parish Medical Society has again begun an investigation of hospital abuses, and a circular of inquiry has been addressed to each member.

Dr. Randell Hunt has been elected surgeon-in-chief of the Shreveport Charity Hospital, to take effect December 1.

The State Board of Medical Examiners passed ten of thirteen applicants for admission to practice in Louisiana.

Twenty-five New Health Boards have recently been established in the State. The bill which was passed at the last session of the Legislature, providing for the establishment of parish boards of health throughout the State, makes it obligatory on the police jury of every parish to organize a parish board of health. Formerly the law required the physicians to live in a parish five years before they could become members of the board, but now a residence of one year as a registered voter in a parish is sufficient for membership on such board of health.

The Mississippi Medical Record is offering to its subscribers a $100 surgical table for the best original essay on any medical or surgical subject handed in before April 1, 1901. For particulars address the editors at Vicksburg, Miss.

Messrs. W. B. Saunders & Co., the well-known Philadelphia publishers, have opened a branch of their establishment in London. We are glad to gather that this move has been justified by an apparent demand, and wish the venture every success. A number of new publications are announced for an early date.

A Scholarship in Pharmacy has been established at the Philadelphia College of Pharmacy, by Messrs. Keasby & Mattison. This will be free to successful applicants after a competitive examination. Persons interested may address the Dean of the Faculty.

Married: Dr. Jno. T. Jones and Miss May J. Barker, both of this city, were married Octoder 10, 1900.

Personal: Dr. C. P. Wertenbaker, of the New Orleans Station of the U. S. M. H. S., has returned after active duty in Galveston relief work. Dr. H. R. Carter is now stationed at Louisville.

Drs. L. G. LeBeuf, F. Larue, E. S. Lewis, S. M. Fortier, J. B. Elliott, Sr., have returned after a summer vacation.

Dr. J. B. Murphy and Dr. Archibald Church, of Chicago, have been elected respectively to the chairs of clinical surgery and nervous and mental diseases in the Northwestern University Medical School.

Died: Dr. J. M. DaCosta, aged 67, at Philadelphia, September 11; Dr. Hunter McGuire, aged 65, at Richmond, September 19; Dr. Lewis A. Sayre, aged 80, of New York, September 21; Dr. Alfred Stillé, aged 87, of Philadelphia, September 24; Dr. T. J. Woolf, aged 48, at Denver, October 1.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

The Refraction of the Eye. A Manual for Students. By GUSTAVUS HARTRIDGE, F. R. C. S. Tenth Edition. 1900. Illustrated. 12mo. P. Blakiston's Son & Co., Philadelphia.

Our favorable opinion of "Hartridge on Refraction" has been so often expressed that to repeat it apropos of this the tenth edition would be a work of supererogation indeed. H. D. B.

Diseases of the Stomach. Second Enlarged and Revised Edition. By JOHN C. HEMMETER, M. B., M. D., PH. D. P. Blakiston's Son & Co., Philadelphia, 1900.

The present edition of this most excellent work is easily the best of its kind by an American author.

Almost the entire book has been revised. The most important additions are articles on the following subjects: Hypertrophic Stenosis of the Pylorus; Obstruction of the Orifices; The Use and Abuse of Rest; and Exercise in the Treatment of Digestive Diseases.

New illustrations and plates, the work of Mr. Louis Schmidt and Mr. Herman Becker, have been inserted.

As stated in our review of the first edition: 'We think that the chapter devoted to the surgical treatment of organic gastric diseases should have been omitted in a work on clinic medicine.' The work reflects great credit upon its author and the profession in America, and should meet with the success that it so well merits. STORCK.

A Text-Book of Practical Therapeutics. By HOBART AMORY HARE, M. D. B. Sc. Lea Brothers & Co.. Philadelphia and New York, 1900.

It is certainly encouraging to notice the success of this work, the present being the eighth edition in less than ten years.

In our several reviews of former editions, we endeavored to point out some of the many good features of the work.

In the present edition we notice a new departure; illustrations showing those portions of the body upon which the drugs exercise their greatest influence.

We predict a still greater success for the present edition of Dr. Hare's work. STORCK.

A Practical Treatise on Medical Diagnosis, Third Edition, revised and enlarged, by JOHN H. MUSSER, M. D. Lea Brothers & Co., Philadelphia and New York, 1900.

It is seldom that we have the pleasure to review such an elaborate work as that by Dr. Musser. The book contains 1062 pages, and deals with the whole subject of diagnosis in its present state of development. The different means and methods of diagnosis are accurately described by conscientious men who are experts in their respective branches. giving this work a position surpassed by none. We fully agree with Dr. Musser when he says:

"Modern research has placed this fundamental branch upon the plane of an exact science, and has correspondingly elevated the whole superstructure of medicine."

The plates on the "Pictoric Records of Physical Signs," by Dr. Thomas S. Kirkbride, Jr., deserve special mention. If the physician is to own only one book on medical diagnosis, let that one be Musser.

STORCK.

Essentials of Medical and Clinical Chemistry, with Laboratory Exercises. By SAMUEL E. WOODY, A. M., M. D. P. Blakiston's Son & Co., Philadelphia, 1900.

We find much in this work to commend itself to medical students. It is well written by a practical and experienced teacher, and shows careful revision. It is undoubtedly one of the best of the smaller text-books on chemistry.

STORCK.

The International Text-book of Surgery, by American and British Authors, Edited by J. COLLINS WARREN, M. D. and A. PEARCE GOULD, M. S., F. R. C. S. In two volumes. W. B. Saunders, Philadelphia, 1900.

This admirable work is completed by the recent issuing of the second volume. The whole field of surgery is treated including even the eye, ear and throat. The writers have been selected with care and the material having been ably edited by Warren in America and Gould in Great Britain represents the state of surgery in both Europe and America at the present day.

The work is comprehensive but concise enough and will, we believe, become very popular as a text-book, but not only students but practitioners of surgery as well will find it a very useful addition to their libraries. The progress of surgery has been so rapid and the views of surgeons differ so much on important points that no surgeon or practitioner should limit himself to any single work on surgery; he is compelled to see the subject from all points of view and must perforce, if he would not be narrow, have in his possession the chief works on surgery. This should certainly be one of them.

PARHAM.

Paralytic Deformities of the Lower Extremities, by E. NOBLE SMITH, M. D. with 51 illustrations. Smith, Elder & Co., London, 1900.

The object of this small work is to review the general aspects of paralytic deformities of the lower extremities, and to discuss the questions which may arise in deciding as to the most effectual treatment to adopt.

Typical examples of deformity are given rather than a complete discussion of subject. The author republishes here his article in the *Lancet*, November 5, 1898, on A New Method of Restoring the Absent Function of Muscles in Infantile Paralysis. This consists in cutting the tendon of the paralyzed muscle, and illustrative cases are given to show the value of his suggestion. The book will be found very interesting and instructive.

PARHAM.

Surgical Anatomy, by JOHN B. DEAVER, M. D., of Philadelphia. In three volumes. Illustrated by about 400 plates, nearly all drawn for this work, from original dissections. Volume II. Neck, mouth, pharynx, larynx, nose, orbit, eye-ball, organ of hearing, brain, male perineum, female perineum.

The second volume of this great work is now before us. No extensive review could do adequate justice to the untiring industry and judgment displayed in the preparation of this surgical anatomy. We can only repeat the commendations bestowed upon the first volume. Should the excellencies of the volume now issued be maintained in the third, the American medical profession will possess a monumental work, which will raise the credit of American surgery abroad and greatly stimulate the study of surgical anatomy at home.

PARHAM.

The Anatomy of the Brain. A text-book for medical students. By RICHARD H. WHITEHEAD, M. D., Professor of Anatomy in the University of North Carolina. 41 engravings, 96 pages. The F. A. Davis Company, Philadelphia: 1900.

This little book will furnish the student of anatomy with a clear and reliable guide in the study of the brain. Endorsement of the recommendations of the German Anatomical Society is given by the insertion of the Latin terms adopted by that Society.

PARHAM.

Essentials of Surgery, being No. 2 of Saunder's Question-Compends Seventh Edition, Revised and Enlarged. BY EDWARD MARTIN, M. D. W. B. Saunders & Co., Philadelphia, 1900.

This little book is arranged in the form of questions and answers, which seem well calculated to give the student, for whom the work is intended, a very good review of the field of surgery. The author states in the preface that he has made "an earnest effort to be accurate, concise and modern" and we think he has succeeded. It is a pity that students must "cram" for examination, but if they must, it is fortunate that they can have books as well prepared as these compends of Saunders seem to be.

PARHAM.

The Pathology and Surgical Treatment of Tumors. BY N. SENN. Second Edition, Revised. W. B. Saunders & Co., Philadelphia, 1900.

This is the second edition of Senn's work on tumors. It has been carefully revised and many additions have been made. As the work now stands it is the product of the best effort of one of America's master surgeons and pathologists. It is a book that no surgeon can do without. It presents the subject of tumors in a thorough way and is written in an

interesting style that can not fail to make the study easy and attractive. The publishers work has been well done and the numerous well selected illustrations add greatly to the value of the book. PARHAM.

Surgical Pathology and Therapeutics. By JOHN COLLINS WARREN, M. D., being the second edition, with an Appendix. W. B. Saunders, & Co., Philadelphia, 1900.

No better book could be placed in the hands of the student of surgery than this. The teaching is sound and up-to-date. The work has not in the main been materially changed, but the Appendix has been greatly enlarged to "embody all the important changes." In this Appendix the author "has aimed to present in as practical manner as possible the resources of surgical pathology. The teaching is sound, and we believe no better work could be recommended to the student of surgical pathology than this. Read, for illustration, the valuable and very interesting chapter on shock and one will be convinced of the value of the work. We can cordially recommend the work as one of the most scholarly and entertaining of which we have any knowledge.

PARHAM.

Diseases of Women: A Treatise on the Principles and Practice of Gynecology, for Students and Practitioners, by E. C. DUDLEY, A. M., M. D., Professor Gynecology, Northwestern University Medical School, etc. Second Edition. Revised and Enlarged. With 453 Illustrations and 8 full-page plates. Lea Brothers & Co., Philadelphia and New York.

The peculiarity of this valuable and highly instructive work rests not so much in the text as in the original arrangement of the subject matter therein contained. For instance, instead of a regional division of the subjects, the chapters are divided along pathologic lines. To illustrate: Chapter Second treats of Inflammation. In this chapter inflammatory conditions, acute and chronic, of every generative organ is discussed. Instead of having to search different chapters for information concerning inflammation of different organs, the student finds the entire list in one chapter. The same holds true for tumors, etc.

Whether the arrangement will become popular remains to be seen. No other writer has, so far as the reviewer can ascertain, adopted the method. It is true that it was but in 1898 that the first edition appeared. And the fact that only one year later a second edition was called for, speaks well for the popularity of the work.

The author has a brief and clear way of saying many truths. For instance: On the curability of chronic endometritis, he truly says that the condition is often difficult of cure, and that relapses are very common. Again, that the customary division of this malady into simple and septic is unscientific and unclinic. Better that it should be purulent and catarrhal than non-purulent. Such a suggestion deserves respectful consideration. His plan of treatment of this disease is rational and scientific.

To fully review everything brought forward in this chapter on Inflammation would take up too much space, as the doctor has treated that subject with an elaborateness seldom seen. And the same reason holds true for the rest of the book.

Unfortunately, in our opinion, too much space has been devoted to that absurdity known as Brandt's System of Massage of the Pelvic Organs. A good suggestion against its use might be a contemplation of figure 450!

A careful study of this second issue, which is more complete than the first, will prove of great service to any student or practitioner.

MICHINARD.

Medicine as a Business Proposition, by G. FRANK LYDSTON, M. D., The Riverton Press, Chicago, 1900.

It required a good deal of courage and of ability not only to approach but to propound this question, since it became necessary for the lecturer to tell us a piece of his mind and to have us take our medicine most gracefully. Everybody in the profession gets his share of straight stings, the lowest and the highest, the author included, by the way, for he confesses to be a part of the vicious circle in which the profession stands. One might feel that there is hardly any hope of getting out of our torments, and that the profession is doomed to what apparently is the counterpart of Dante's Inferno, but personally I believe, with the author, that we can escape many sufferings if we only act by sensible, timely, legitimate aggressiveness and determination toward others and ourselves as well. The brochure now before us will help the timid. It is refreshing to hear an honest and talented physician state that "Self-interest is not reprehensible" in the face of the public with its mawkish, blanket-like sentiments of philanthropy, which is expected to cover both God's and the devil's patient, the pauper and the dead-beat, the honest man and the rascal, the rich and poor alike.

Again, it is comforting to hear from respectable lips this statement that "municipal hospitals must be run *squarely* and *fairly* for charity, and respectable private hospitals run frankly for pecuniary profit, in which the operation and the attendance fees are the chief factors. Such hospitals will benefit, and not hurt the profession," etc. But I believe the author's references to the post-graduate schools as a means of self-aggrandizement are probably too general. A school is like the private hospital he so much approves of. It can not be reprehensible when fully composed of "up-to-date men," actually showing how their material, equipment and earnestness in study, practice and teaching are useful to the profession and to the public. Osler is of the opinion that in America, as in Germany, the poly-clinics have done the greatest amount of good, and I personally believe that Osler's opinion (*British Med. Jour.*, July 14, 1900) justly carries weight.

No practitioner should hesitate to consider seriously the vital question of Medicine as a Business Proposition, or the Business Aspects of Medicine, and for both the present brochure may be warmly recommended.

DUPAQUIER.

A Manual of Obstetrics. by A. F. A. KING, A. M., M. D. Eigth Edition, Revised and enlarged, 264 illustrations. Lea Bros & Co., Philadelphia and New York, Publishers, 1900.

This volume is practically the same as that of two years ago, and is, as it was then, a very instructive little book. MICHINARD.

Atlas and Epitome of Gynecology. By Dr. OSKAR SCAEFFER, Privatdocent of Obstetrics and Gynecology in the University of Heidelberg. Authorized Translation from the Second Revised and Enlarged German Edition. Edited by RICHARD C. NORRIS, A. M., M. D. With 207 Colored Illustrations on 90 Plates, and 62 Illustrations in the Text. W. B. Saunders & Co., Philadelphia, 1900.

It was but a comparatively short while ago that we had the pleasure of reviewing the first edition of this pictorial series of lecture on Gynecology. There can be no question as to the fact that no one has heretofore given such clear and instructive lectures on diseases of women by simple illustration. The mind must be dull, indeed, that can not readily grasp the pathology of gynecology by a careful study of these wonderfully executed pictures. Everything is so clear, so correct, so well brought out that one could hardly expect an improvement. The publisher and the translator certainly deserve a great deal of credit. The highly complimentary comments made on the value of the first edition can only be repeated on the fuller and more comprehensive second edition. MICHINARD.

Gynecology. A Manual for Students and Practitioners. By M. A. CROCKETT, M. D., Adjunct Professor Gynecology University of Buffalo, and by B. B. GALLAUDET, M. D. 107 Engravings. Lea Brothers & Co., Philadelphia and New York, 1900.

This book, that the publishers call a "Pocket Text-Book," is an admirably arranged little volume, and reflects a great deal of credit on the writers. For a first attempt these gentlemen have made an unusually successful effort at book construction. The work is rather small, but even so it contains a great deal of instruction clearly presented. Students will find it a good guide. MICHINARD.

Medical Diseases of Infancy and Childhood. By DAWSON WILLIAMS, M. D., London. Second American Edition. Revised with additions by FRANK SPOONER CHURCHILL, M. D., Chicago. Lea Brothers & Co., Philadelphia and New York, 1900.

We take pleasure in stating that this edition is altogether a new book. The work has been brought up to date and adapted to the special requirements of this country, representing American views, and the original prescriptions have been conformed to the U. S P. The combination of Dr. Williams' long experience and of the most modern views in the same book gives it much value. DUPAQUIER.

A Practical Treatise on Sexual Disorders of the Male and Female, by ROBERT W. TAYLOR, A. M., M. D. Lea Bros. & Co., Philadelphia and New York, 1900.

This is the second edition of a valuable work. Five chapters have been added, and some have been either rewritten or enlarged. The illustrations are 91 and the chapters 13, as compared to 73 and 8 in the first edition. The entire subject is satisfactorily and pretty thoroughly considered. We can simply repeat, perhaps somewhat more emphatically, the closing paragraph of our review of the first edition:

"A proper understanding on the part of physicians in general of the

descriptions and of the advice given by Dr. Taylor would prove of vast service to a number of unfortunates who are turned away as having nothing the matter with them, to become the prey of unscrupulous quacks. It would lead to one of two things: either these physicians would treat them scientifically and successfully, or, if they did not want to take this trouble, they would see the necessity for guiding them to reputable specialists who could do them justice." C. C.

Studies in the Psychology of Sex. By HAVELOCK ELLIS. The F. A. Davis Co., Philadelphia, New York and Chicago, 1900.

The contribution of a work like this is a long step towards the education of medical and scientific men in fields new to most of them.

The basis of most of the present regulations of community life is derived from the sexual obligations, and even though the phallic laws are obsolete as such, sex instincts are yet active. The larger half of the present world is under sex custom, if not law, and it is timely that so important a phase as the psychology of sex should be appreciated. Havelock Ellis has for years occupied a distinguished position as the student of ethnologic and anthropologic questions, and his contributions hitherto have added valuable data to the study of morbid conditions in the neuro-psychic system, even yet little understood. The relation of these to sexual conditions is every day more patent to those who study the human type.

Every medical man should read the "Psychology of Sex" for the better understandnig of his kind.

The book in precise detail relates the evolution of the modern sense of modesty, especially as referred to sexual relations; it considers functions and customs correlated; finally, *in extenso*, the author handles in a graphic, classic way the various phases of the sexual instinct as it develops from time to time under the impulses, unconsciously born and stimulated in either sex, without the provocation of the other sex.

The work is replete with references and quotations which attest the research and painstaking labor of the author. DYER.

A Treatise on Diseases of the Nose and Throat. By ERNEST L. SHURLEY M. D. D. Appleton & Co., New York, 1900.

Laryngologists have long waited for a work of this kind from the pen of this eminent and well experienced clinician and teacher, and hail the the appearance of this volume with pure satisfaction. The work is one designed for the guidance of the student and the general practitioner of medicine, but is so fraught with valuable information for the specialist as to render it a most desirable acquisition to his library. The author confines himself particularly to facts gleaned from practical experience and observation in his own work as well as that of others, and gives little space to useless theorizing and speculation. The text is richly illustrated with anatomic and other illustrations, microphotographs, and colored plates of diseased conditions of the nose and throat.

At the end is an extensive formulary of remedies in general use. The chapters on Diphtheria and Neuroses of the Upper Air Passages are of special interest, and the latter particularly is devoted to an important subject which has but bare consideration in most of the text-books of the day. Tuberculosis of the Upper Air Passages is also treated ably and at length. The book is a credit to its author and a valuab'e addition to our resources. DE ROALDES AND KING.

Thorington. Refraction and How to Refract. By JAMES THORINGTON, A. M., M. D. P. Blakiston's Son & Co., 1900.

Although the author modestly claims to have written this work for the benefit of beginners and those of limited knowledge of mathematics, we believe that it not only is valuable in that particular, but furnishes in a pithy manner to the more mature refractionist the methods and experience of an able and careful worker. ROBIN.

PUBLICATIONS RECEIVED.

Transactions of the Medical Society of the State of New York, 1900.

The Student's Medical Dictionary, by Geo. M. Gould, M. D.—P. Blakiston's Son & Co., Philadelphia, 1900.

Transactions of the American Surgical Association, 1900.

A Treatise on Medical Diseases, by Henry J. Berkley, M. D.—D. Appleton & Co., New York, 1900.

A Treatise on Diseases of the Nose and Throat, by Ernest L. Shurly, M. D.—D. Appleton & Co., New York, 1900.

Practical Gynecology, by E. E. Montg omery, M. D.—P. Blakis ton's Son & Co., Philadelphia, 1900.

Progressive Medicine, Vol. III, September, 1900.

Diseases of the Thorax and Its Viscera, etc., Lea Brothers & Co., Philadelphia and New York, 1900.

Transactions of the Louisiana State Medical Society.—New Orleans, 1900.

A Manual of Otology, by Gorham Bacon, M. D.—Lea Bros. & Co., New York and Philadelphia, 1900.

A Practical Treatise on Genito-Urinary and Venereal Diseases and Syphilis, by Robert W. Taylor, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

Twentieth Century Practice of Medicine. Volume XX. Edited by Thomas L. Stedman, M. D.—William Wood & Company, New York, 1900.

Announcement New Orleans College of Pharmacy, 1900-1901.

A Dictionary of Medical Science, by Robley Dunglison, M. D. —Lea Bros. & Co., Philadelphia and New York, 1900.

Manual of the Diseases of the Eye, by Charles H. May, M. D. —William Wood & Company, New York, 1900.

Address before the American Dermatological Association, by Henry W. Stelwagon, M. D., President, 1900.

Pathology and Morbid Anatomy, by T. Henry Green, M. D.— Lea Bros. & Co., Philadelphia and New York, 1900.

A Practical Treatise on Fractures and Dislocations, by Lewis A. Stimson, M. D.—Lea Bros. & Co., New York and Philadelphia, 1900.

Index—Catalogue of the Library of the Surgeon General's Office, United States Army, Vol. V.—Government Printing Office, Washington, 1900.

Reprints.

Submucous Ligature for Rectal Hæmorrhoids and Prolapse, by B. Merrill Rickets, M. D.

Report of the Committee of the American Surgical Association on the Medico-Legal Relations of the X-Rays.

Two Cases of General Anesthesia, by Charles W. Burr, M. D.

Some Points in the Management of Obstetric Cases in Private Practice, by Joseph Brown Cooke, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR SEPTEMBER, 1900.

CAUSE.	White	Colored	Total
Fever, Malarial (unclassified)	8	5	13
" " Intermittent			
" " Remittent	3	2	5
" " Congestive	5		5
" " Typho	2	3	5
" Yellow			
" Typhoid or Enteric	7	2	9
" Puerperal	1		1
Influenza			
Measles			
Diphtheria	4		4
Whooping Cough			
Apoplexy	4	6	10
Congestion of Brain	1		1
Meningitis	2	2	4
Pneumonia	14	9	23
Bronchitis	9	2	11
Cancer	8	3	11
Consumption	23	30	53
Bright's Disease (Nephritis)	27	21	48
Uremia	2		2
Diarrhea (Enteritis)	9	6	15
Gastro-Enteritis	4		4
Dysentery	2	2	4
Hepatitis	3	2	5
Hepatic Cirrhosis	3	1	4
Peritonitis	2		2
Debility, General	3	4	7
" Senile	17	7	24
" Infantile		6	6
Heart, Diseases of	20	14	34
Tetanus, Idiopathic			
" Traumatic	7	4	11
Trismus Nascentium	6	4	10
Injuries	12	10	22
Suicide	4		4
All Other Causes	79	55	134
TOTAL	291	200	491

Still-born Children—White, 14; colored, 21; total, 35.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 16.63; colored, 27.78; total, 19.64.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.00
Mean temperature	82.
Total precipitation, inches	3.76

Prevailing direction of wind, southeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. DECEMBER, 1900. No. 6.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

MEDICAL TREATMENT IN DISEASES OF THE KIDNEY.*

BY L. G. LEBEUF, M. D., NEW ORLEANS.

I believe it was Trousseau who said that medicine was the science *par excellence* of all sciences, and that no preparatory work or study a man may have ever done would be superfluous in the latter practice of the profession of medicine. Certainly this is amply illustrated when we attempt to deal with renal diseases and apply an intelligent treatment to the affections of the kidneys. It is most true, then, that the physician who has had a thorough preparation in chemistry and other laboratory work is much better fitted to deal with these subjects, after going through the regular curriculum of a modern college life, than he was many years ago. We have not only to deal with the histology, the etiology and the clinic course of renal diseases when we try to apply a treatment to them, but we have to understand the entire chemistry of the organ so as to appreciate the processes of change in destruction and impaired function. This is not a system with a given set of diseases which can be reached by a specific drug. In the whole domain of therapeutics we have no one specific for renal diseases. The two means

*Read before the Orleans Parish Medical Society, August 25 1900, New Orleans.

through which the greatest good has been accomplished, if the secret was honestly admitted, would not be found in our works on materia medica, but could be answered in two words: First, judicious dieting; second, alkaline draughts and diuretics. Place the kidneys in a sling, as it were; place as little work on them as possible whenever they are diseased; use saline purgatives, aperient waters; diminish nitrogenous or irritating food: increase diaphoresis, cause the great emunctory organ, the skin, to make up for some of its functions. In fact, in most renal conditions we should try to do for the kidneys exactly what digitalis does for the heart, when that organ is affected. It is clear that we should separate the treatment of acute nephritis from the chronic degenerative forms of other renal disorders, because in the acute, the causation, the duration and the whole course is so different from the chronic type.

Acute nephritis is known under the following names: Acute parenchymatous nephritis, acute nephritis, acute diffuse nephritis, acute desquamative nephritis, acute tubular nephritis, acute Bright's disease, acute albuminous nephritis, acute hemorrhagic nephritis, acute albuminuria. The tubular, vascular and interstitial tissues are all affected in this disease; the prognosis is generally favorable, as the course is short, and as it is most often dependent on or symptomatic of other diseases, as scarlet fever, diphtheria, malaria, pregnancy, etc. It is often due to some irritating drug, as cantharides, turpentine, etc. Most conditions of acute nephritis, if properly understood, especially as to cause, should be easily controlled. The principal desideratum will be rest, absolute quiet mentally as well as physically, warmth and diet. Take for instance the acute nephritis of children dependent upon scarlatina. All such cases should be left quiet in bed, clad in warm woollen clothes, and with restricted diet. Treat even the mildest case by prophylaxis, as the dangers are frightful when neglected, for aside from the toxemia which arises from the inactivity of the kidneys, and the additional toxemia of the scarlet fever poison itself, there is also in many cases further poisoning or sepsis from infection derived from other micro-organisms, such as the streptococcus. The height of the fever, the severity of the attack, the pulmonary condition, the pharyngeal complications affect and influence the treatment of acute nephritis of

scarlatina. As I have just said, let the main part of all treatment be by a *vis a fronte*. Indeed, if a prophylactic treatment was ever indicated it is in this affection. We must try and recognize the disease early so we can obviate all the severe complications of this nephritis by taking precautionary measures. So many cases of what is called light attacks of scarlet fever are allowed to walk about disguising the outset of serious renal complications which have not been carefully looked for until some sudden congestion or degeneration takes place; uremia or chronic nephritis follow very often. Many of us can remember our own recent experience in the treatment of nephritis complicating yellow fever and still keep in mind a vivid picture of the same danger. We should administer mild alkaline diuretics, give the patients pure water almost *ad libitum*, aerated and lightly carbonated by preference; of course purgatives are the real base of the treatment; the idea is to try and rid the body of the toxic material through the bowels by improving and increasing the intestinal circulation. The treatment of the skin in some cases of acute renal trouble is most important. Diaphoresis has always been recognized as one of the essential things to establish. In uremia when you want to create a vicarious elimination of urea, the primary indication is to start as free and copious a perspiration as possible. Still, Professor Hare gives us statistics that are not encouragiug of any great good being accomplished in this wise. He finds out that the urin passed in twenty-four hours amounts to 23,350 grains, of which 1116 grains are solids, while the perspiration in twenty-hours amounts to 20,925 grains, of which 1 per cent. or 209.25 grains are solids and only a *fraction of one grain is urea*. This does not help us much in the hope that the emunctory elimination of urea is of great help when we remember that the normal amount of urea in twenty-four hours should be about 511 grains. Hydrotherapy is of prime importance in this condition; the circulation is stimulated by alternate cold and warm sponging, whilst friction helps often to prevent stasis in swollen, congested kidneys. I have seen large warm salin enemas used and serve a good purpose of elimination. Full body baths increase the amount of fluids in the blood and help also to eliminate toxins. We often see benefit from sprinkling or dashing of water alternately cold and warm in the

advanced stages of toxemic poisoning. All this also helps the circulation as well as it increases the action of the skin capillaries and emunctories. The hot wet pack and stupes over the lumbar region are most beneficial, as well as the use of dry cupping. It has been my good fortune to see at least three cases of renal congestion of malarial origin relieved by cupping, and I do not think we should ignore this method entirely; it certainly acts as well as a blister in other conditions of congestion. Wet cupping should not be used except in very severe cases, and care must be taken not to scarify too deeply. Diet is an essential of acute nephritis, especially as regards discarding albuminous foods. This should consist of thin chicken tea (no rich beef extracts), rice and farinaceous preparations, strained oat-meal, Imperial Granum, Vitos, etc. As the acute stages of renal diseases are generally short in their course it is indicated to give the absorptive organs as little work as possible. Certainly we have proven that fact in the very successful way this complication of yellow fever has always been so happily met with by the profession of this city. The diuretics and diaphoretics, with the purgatives mostly used in this disease are numerous. We should remember that in the use of medicinal agents we are trying to relieve a morbid condition marked by considerable pain, by fever, often headache, vomiting and decidedly reduced quantity of urin, often bloody. I will name a few of the agents that are mostly used: potash bitartrate, citrate and sulphate of magnesia, spirits of nitrous ether, jaborandi, pilocarpin, juniper berries, digitalis (infusion of digitalis by preference, because more digitalis is used in this manner), acetate and citrate of potash, caffein, strophanthus, diuretin (or salicylate-sodio-theobromol) and fuchsin. These are only a few of the most frequently used agents, and many times we feel that even these are used too freely and at haphazard without proper regard to individual conditions. Digitalis, with which we are so free in renal diseases, has many objections from noted physiologists. It is given as a diuretic because, by increasing blood pressure, it acts upon the freer transudation of fluids from the renal blood vessels. But it has a much more complex action than this and really acts as a diuretic only in the nephrites which are complicated by heart lesions. Of course the blood pressure is increased

by digitalis increasing the cardiac stroke, and at the same time contracting many small vessels; hence if the increase of blood pressure is counterbalanced by the constriction of small vessels, it must necessarily also constrict the renal vessels themselves. If we admit that it acts as a diuretic in cardiac diseases, we must accept also that it is also a diuretic in other conditions of nephritis, and the theory is that it has a peculiar unexplained effect on the epithelial tubules themselves, or the constricting effect it has on the renal blood vessels must necessarily be less than its effect on the other small arteries, or that there must be a difference in the time at which these two constrictions take place. On the other hand, in acute nephritis, we often wonder whether we are not doing harm in using any diuretic. Prof. Andrew Smith says that they act in three ways, 1st, by direct stimulation of the parenchyma of the kidneys; 2d, by increasing the amount of water in the blood; 3d, by raising the general vascular tension. When we remember that in acute nephritis we have already a hyperemia where there is a large accumulation of blood to the part and a pathologic formation of cells, we can readily see that an increase in that formation and generation can do harm. This is made more plain to us when we review the number of drugs, like cantharides, turpentine, cubebs and others, which in large doses cause this disease themselves.

In uremia and in uremic convulsions we have the right to use the more powerful drugs, which we should always fear to employ in the milder conditions. Croton oil, elaterium, muriate of pilocarpin, jaborandi, by enema or in suppositories, atropia and strychnin in edema of the lungs, chloral hydrate, chloroform, and even morphin in convulsions. Morphin should never be used except in the worst and most violent stages of the convulsions of acute nephritis.

When we attempt to deal with the two chronic types of nephritic diseases we have reached conditions which can no longer be prevented, and all our prophylaxis must consist in the study of the individual characteristics, the intelligent regulating of a conservative as well as sufficiently nourishing diet, as well as proper but restricted exercise. The essential in this exercise is to always hold in mind the amount of pressure that the exercise places on the heart, and never overdo it. Diet

very naturally again, is the mooted question in chronic nephritis of either kind, and it has been the most hackneyed of all subjects in discussing the treatment of these diseases. There should be no iron-clad rules from which individual tendencies or characteristics can not depart; each case should be a study of its own requisites and possibilities. Prof. H. A. Hare says on this subject: "Many cases of chronic contracted kidney can have a liberal diet, provided it is one which is easily digested and not calculated to produce gastric and intestinal disturbances. In other words, these patients need not have their meat cut from the diet list, but should be allowed to take good wholesome food, provided that it is not taken in excessive quantities."

Hence we see though it is not right to eat eggs and strongly albuminous meats in the chronic parenchymatous form of nephritis, still many highly competent authorities and specialists of note consider that the patient is deprived of an important item of diet, one which, when taken in moderation, is of prime importance and helps to make up the destructive elements. If eggs and meats are used note the effect on the kidney. The test tube should be the barometer of their use.

The two chronic forms are the chronic parenchymatous and the chronic interstitial nephritis. Chronic parenchymatous, or chronic diffuse nephritis, chronic tubular nephritis, chronic catarrhal nephritis, or the large white kidney, is a diffuse hyperplastic process in the kidney, involving the epithelium, the glomerules, and in advanced conditions the interstitial tissues. It is almost always fatal, though treatment can delay this for a long while. Tyson gives two principles for treatment; first, to improve the quality of the blood, which may have become anemic and toxemic, contaminated with urea and other effete matter, and second, to combat the symptoms and complications which inconvenience and endanger patients so much. With regard to the first indication mentioned by Tyson, certainly it has been the experience of all the clinicians of the day, that in the administration of drugs there is no field where experimental medication has been used as much as in the treatment of chronic parenchymatous affections, and with as much material injury. Of course the essential in parenchymatous conditions, where the secreting function is

markedly diminished, is to increase that power. We should endeavor to diminish anemia by the use of iron, strychnia, the cinchona and Peruvian bark preparations, as well as quassia and the other bitters. It is very important to remember that in the use of iron it is much better to use small doses repeated often; never constipate; watch the stools carefully, and stop the drug the moment the stools are darkened too much. I am very fond of Gude's preparation of pepto-mangan in these cases. Diet is of prime importance, and should be of a light, nutritious form. Milk, if it is pleasant to the patient, from two to three quarts per day. Buttermilk, vichy, the carbonated waters; rest in bed in an even temperature in aggravated conditions. Light but warm clothing induce a certain skin moisture; heat is very important. Even in the diluents, or the water drunk, we should be careful. The learned paper we heard on the pathology of this disease at our last meeting told us that the scanty urin and pathology of the chronic parenchymatous conditions were due to the inactivity of the renal epithelium in the tubules, hence diuresis should be used to increase the fluid flow. Citrate of caffein, the bitartrate of potash and the juniper berries are excellent here. If the heart is too weak and the renal stasis is due to arterial pressure the scanty renal secretion is often helped by digitalis and strophanthus. Many use copious draughts of plain water, but that should not be advised indiscriminately without first studying the special requirements of each patient. If you have a patient with dropsy, the kidneys will not succeed in eliminating the water in time, and as we saw above how little the skin can help, we often cause a damming up of the renal circulation, which would only increase the condition of dropsy. In fact, this day, where happily for us a reaction of conservatism has swept through the profession with regard to the proper handling of parenchymatous affections of the kidneys, one is free to admit that we have no one drug to hold forth as a specific. All those that were recommended as such, specially the vegetable astringents or the other would be called diuretics, which were supposed to eliminate the production of albumin by the contracting of the renal blood vessels, one now knows to be dangerous. To escape the Scylla of renal danger in uremia by non-elimination do we not fall in the more dan-

gerous Charybdis, by keeping the toxins and impurities in the system through diminished renal vessels? Let us not reproach ourselves with the crime of doing too much, in dealing with the second indication referred to by Dr. Tyson—*i. e.*, to learn how to throw out toxic impurities and to combat and bring a remedy to all the symptoms and complications of that disease. Naturally it is well to have a general plan of battle against the pathology of that disease to hold in one's mind a distinct line of medication, but when complications arise and other symptoms set in we should be prepared to meet them also. Keep one's infantry engaged always, but be ever ready in any emergency to unmask your artillery as well as your cavalry. With this underlying principle let us use all the regular armamentarium of our regular technic of drugs, and when complications arise let us not hesitate to apply other measures, even so heroic as they might appear. We sometimes check severe dropsy almost entirely with large doses of jalap, mercuric chloride and apocynum cannabinum. Mercury is a very dangerous drug in most conditions of this affection and has to be watched very carefully. Apocynum cannabinum has given excellent results in the hands of some, and absolutely negative results in others. A distinguished member of our body has had a long experience of nearly unbroken success with it. I suppose it all depends on the preparation whether it is extracted from the right plant or not. Pereira brava has given me excellent results. The National Formulary contains a formula for a fluid extract which seems to act specially well in ascitic conditions.

Finally, with regard to treatment of chronic diffuse or parenchymatous nephritis, the essential is elimination of albumin—do that by judicious diluents, non-depressing diaphoresis, by Turkish baths, hot-pack and vapor baths, gentle catharsis, hydragogue cathartics acting secondarily on the liver, but use diuretics most guardedly. In diet, though it should be vigorous it should not sacrifice the sustaining powers of the patient to the too great desire of withdrawing albuminous matters from him. Many authors think on the contrary, that in this affection, the sick should be given albuminous matter to make up for the large destruction and elimination of albumin taking place in the body.

Chronic interstitial nephritis or the contracted kidney, renal cirrhosis, the cirrhotic kidney, the granular degenerative kidney, the gouty kidney, renal sclerosis or the red granular kidney, is a chronic process resulting ultimately in a shrunken kidney, and in which there has been extensive destruction of the tubular substance and an overgrowth of the inter-tubular connective tissue. There is present nearly always a marked hypertrophy of the left ventricle of the heart. It is complicated most frequently by bronchitis, endocarditis, pericarditis, pneumonia or pleurisy. As this affection is of long duration and marked by very little presence of albumin we have to study very carefully the accidents that may arise. Nearly all that has been said previously should hold good here, except that the same régime need not be kept regarding albuminous matters, meats, etc., and further, as there is a larger quantity of fluid secreted, the necessity is not so great to increase diluents. Gout and heredity have an important role to play in this affection, so the elimination of the uric acid must be looked after. Have the test for urea made frequently, and endeavor to keep it at its normal proportion. Strong alcoholic drinks should be stopped, only the lighter red wines, lager beer or porter or ale should be used and only sparingly. White meats should be used and a light nutritious diet. The hygiene of the body must be perfect; never keep the feet wet; use no salt baths. Life must be very easy; no mental or physical strain of any kind; place the patient in a warm equable climate in preference. Avoid using iron, keep gentle catharsis through Frederichshall waters, aperient purgatives like Hunyadi Janos, Apenta or Rubinat. In drugs the special indication is to relieve a too great arterial tension. Nitroglycerin seems to be the agent which gives the most relief in this affection. When the heart needs additional help it should be supported by strychnin, caffein, spartein, etc. In the dreadful cephalalgia complicating interstitial nephritis, trional, sulphonal, chloral and the bromides are principally indicated. Chloral is always dangerous and must be watched most carefully. Iodide of potash is used as a general treatment. In the retinitis so often complicating the disease we find bichloride of mercury acting almost like a specific. The use of the diuretics must be set aside almost entirely, except in the last stages when the heart has begun to fail and the aperients do not

succeed in carrying off the proper elimination. Pilocarpin or atropin can be used in edema of the lungs. Salin infusion has been used with benefit in this affection, especially in uremia. Venesection and dry cupping also has given good results in this stage. One should never use morphin in the contracted kidneys. Sir George Johnson advises against it. Tirard says: "I have always refrained from the use of a drug which might produce present comfort at the cost of the life of the patient."

The waxy or the lardaceous kidney, where the tissues are infiltrated by a substance of an albuminous composition, which when cut and treated with iodin gives a deep red mahogany color, is due to suppurative diseases, syphilis or phthisis pulmonalis.

Hematuria, hemoglobinuria and chyluria are diseases dependent, as you may say, on other diseases, and should be treated *pro re nata:* Hematuria, by quinin, strychnin, iron, arsenic, local blisters, turpentine and rest, by the regular astringents, the fluid extract of hamamelis-virginica; hemoglobinuria, where the coloring matter of the blood is found in urin, without any cells, if due to anemia, remove the cause and treat on general principles, iron, astringents, etc.; in chyluria, where the secretion is mixed with fat, there is demonstrated also the presence of a filaria. No certain treatment has been found yet for it; the astringents are used, gallic acid, tannic acid, the acetate of lead and the mineral acids.

Suppurative interstitial nephritis, pylo-nephritis, para and peri-nephritic abscesses, tuberculosis and nephro-lithiasis belong to the domain of the surgeon.

Finally, I wish to call attention to the importance which should be given to the diet and to the character of the water used in both lithuria as well as in oxaluria. Diet in the uric acid diathesis should curtail all nitrogenous foods, use very little meat, but a great deal of milk and vegetables. While, on the contrary, in the phosphatic diathesis use the exact opposite. Use meat, but avoid all chances to alkalinize the urine. Again, in the uric acid cases supply the alkalin waters freely, such as vichy, Saratoga and the less strongly alkalin Bedford Springs, Poland, Waukesha and Buffalo lithia. And in the phosphatic tendency, where we have no really acid waters, we have to use the neutral waters or give benzoic or boracic acid with Kissingen water. Exercise is also a primary factor in all the diathetic conditions which require to be looked after.

In conclusion, I wish to say that the spirit of the age is strongly against marked medication, and that outside of accidents and complications which necessarily have to be looked after, the modern specialist will soon deal with renal diseases entirely through the diet and the individual hygiene of the body; in fact endeavor to treat Bright's disease under the same principle with which he treats diabetes.

THE COMMONER AFFECTIONS OF THE HANDS AND FEET AND THEIR TREATMENT.*

BY ISADORE DYER, PH. B (YALE), M D., PROFESSOR ON DISEASES OF THE SKIN AND SECRETARY NEW ORLEANS POLYCLINIC; LECTURER AND CLINICAL INSTRUCTOR ON DERMATOLOGY, MEDICAL DEPARTMENT TULANE UNIVERSITY; VISITING DERMATOLOGIST TO CHARITY HOSPITAL, ETC., NEW ORLEANS.

The various phases of the practice of the general practitioner embrace such a multiformity of obligations to his profession that he seldom gives thought to the smaller ills of the human kind. This is so frequently true that the patient himself has grown accustomed to the impression that certain conditions do not fall within the province of the physician's care. This is brought home at many times to those of us who specialize the practice of diseases of the skin, when the average layman, or better laywoman, gathers the idea that our work does not go beyond the bad complexion and congener affections.

The barber has to a large extent constituted himself a specialist on the scalp and ignorantly dispenses nostrums, for the most part of no service, and for a large part of positive harmfulness. In a like manner the druggist has grown into the office of adviser to the public in matters of smaller import, just because the patient either believes the physician does not care, or else does not know what to do in minor affections. So a field has arisen for a set of special workmen, affecting the care of the digital extremities and the members carrying them, the manicures and pedicures, or chiropodists. Their work aims at relieving conditions of the hands and feet thought to be beneath the notice of the man who practices medicine. Because of their practice in many particulars, the need of their services grows

*Read before the Louisiana State Medical Society, New Orleans, April, 1900.

more and more plausible and the trade has grown into a regular commodity.

A highly interesting and amusing article appeared in the Cincinnati *Lancet-Clinic* during the past year dealing with corns, in which the baneful practices of the chiropodist were detailed, and in which an appeal was made for an intelligent discourse on the affections of the feet, for the better enlightenment of the medical profession, with the expressed hope that it might lead to the assumption of their own work in this regard by the men who profess to treat the ills of the human kind.

This is the excuse for my paper, and I mean what may be presented to stimulate some discussion so as to result in a better care of the little things in our practice rather than to put myself forward as the exponent of authoritative methods.

The scope of my paper implies a broad interpretation, but the purpose is only to call attention to what may properly be called the commoner affections of the hands and feet, viz.: corns and bunions, warts and diseases of the nails, and conditions due to the sweat glands.

In summer especially many persons complain of hands and feet perspiring, particularly the feet, and very little relief is found outside of the old woman's remedies and such agents as are supplied either by drugstores or pretending advertising concerns.

The average physician is ignorant of the remedy; considers half the time the matter of small consequence; suggests a little borax or boracic acid, and dismisses the patient with small comfort. Frequently the sweating process persists and finally results in a chronic condition of hyperidrosis, hard to relieve and often complicated with a tendency to inflammation, which may cause much pain, and which may put the patient in bed. Every summer, at times during other seasons, the last named patients get under my care, always with a history of previous sweating feet or sweating hands. Recently I had a patient with both hands incapacitated by the mass of vesicles from such a cause, diagnosed, however, eczema by the family and friends.

The condition is fairly easy of relief. Begin by ascertaining the kind of soap used, and advise white castile. Ascertain the habits of the patient and restrict excessive drink. Give small

doses of strychnin internally (not arsenic) over a long period, say six or eight weeks. Locally, for the hands use a solution (3 to 5 per cent.) of salicylic acid in alcohol frequently during the day. For the feet, a like remedy will answer, best used in powder form; say salicylic acid ½ drachm, tannin 1 drachm, powdered arrowroot ½ ounce, rice starch ½ ounce; dust this in the stockings every day. Where the feet are inflamed and not blistered, simple bathing for 20 or 30 minutes in hot water, with 4 ounces of laundry starch to the gallon, will be of service, before the use of the powder. Where the condition is more chronic lead water may be used on cloths, which should swathe the feet at bed time; the powder in the morning. Frequently the blisters suppurate, in which event, nothing serves better than a 5 to 10 per cent. watery solution of ichthyol kept applied.

The manicures and pedicures thrive on the negligence of the physician. They cultivate a clientele among people who become persuaded that it is necessary to keep a corn cut, to keep ingrown nails trained in and that any other system or method is fallacious.

The commoner conditions of the nails of the hands and feet are these: Agnails, or "hangnails"; paronychia, or "run-a-round"; horn-nail; ingrown nail; felon.

The agnail often causes the paronychia and as often the felon. Usually begun by an accidental tearing up of the skin on the side of the nail, the person affected customarily begins by trying to tear or bite it off until a little band of bleeding surface is left, ready for infection, which comes. Don't tear the nail; just lay it in place and paint plain flexible collodion over it and in three days it will be well. When infection has occurred touch the spot with pure carbolic acid (mop afterwards with alcohol), or touch it with the nitrate of silver stick. When the the infection goes further, nothing serves so well as a 1-1000 bichloride dressing kept constantly wet with the same strength of solution. This frequently serves the purpose in two or three days. I have often aborted felons with this dressing, which is so much more sane than the soap and sugar and other poultices of the commoner practice. The surgical procedure for the matured "run-around" or felon needs only mention here.

The ingrown nail can not get well constantly by cutting the

upper corner out; it is in fact the best way in the world to cultivate this condition, for it forces the nail to grow in because it can not grow out. The nail should be carefully watched and one of several procedures may be followed. Either the nail can be regularly scraped in the centre and a V-shaped piece cut from the centre of the free nail, or this thinning of the nail can be accomplished with liquor potassæ frequently applied, and after several applications then the nail may be scraped. Clips are now to be had for the purpose of keeping the flesh lifted from the nail so as to prevent pressure until the nail grows.

Where the condition is very chronic there are several methods of relief: 1. Remove the nail entire. 2. Remove the half or one-third of the nail on the side affected. 3. Remove the skin and redundant tissue from the side of the finger or toe affected and then use plasters to force the healing process away from the nail. Of the last method there are several modifications, each of which affords the desired relief.

Warts seldom occur on the feet, when they do they are most often of the acuminate type and are found between the digits. Salicylic acid, bismuth subnitrate and calomel, in equal proporand dusted on regularly, will usually serve to dry these up. Warts on the hands are usually flat or they are acuminate. The last are the most troublesome. The flat warts will almost always disappear under a daily painting with salicylic acid in collodion (5 per cent.). The acuminate type is more deeply seated and salicylic acid more often fails than not. The burying of a string drawn through the wart, staining a corn grain with the blood and planting it, charms and pow-wows are all effective in degree, if you can believe in the spiritual character of the wart; otherwise tangible remedies are necessary. As a rule I remove warts with the thermocautery (Paquelin). Next of value is the glacial acetic acid, which must be used carefully. Sometimes the curette and the silver stick will answer, particularly where the wart is pedunculated. Formalin solution will gradually harden and crumble off a mass of warts if they are not too cornified. Where there are numerous warts on the hands a combination of corrosive sublimate (gr. 3) and sulphur (drachm 1) in cold cream (½ ounce) is serviceable. It must be well rubbed in and left on over night; the process to be repeated until the skin becomes too sore, or the warts vanish. Arsenic

(gr. 2) in mercurial ointment (½ ounce) is also suggested and should be useful. The electric needle will remove a wart, but the pain is severe and the result less determinate than in the preceding measures.

Corns and Bunions.—These conditions are the price which civilization pays for appearances. The bunion is the result of a shoe too short or too narrow causing at first pressure, then deformity at the first joint of the great or little toe. Sometimes the term is used to apply to enlargements of joints at other points on the feet. Rarely rheumatism and gout determine these conditions, but usually there is sufficient evidence to be deduced.

A bunion of long standing becomes a purely surgical condition and needs surgical interference for the removal of the overgrowth of bone or periosteum. Ordinarily, the condition is relieved of pain by wearing looser shoes and by protecting the painful part with a simple cotton and collodion dressing. Where treatment is indicated, the cotton can be saturated with a mixture of carbolic acid, camphor and alcohol. A useful and conveneint remedy is the tincture of iodin. It should be combined with chloral or tincture of cannabis Indica. The diachylon plaster of Unna gives relief where the surface is large. The bathing in starch water is always advisable and should be practiced twice a day. Some have urged that the starch baths persisted in will gradually dissolve the deposit in a gouty foot.

There are several kinds of corns and the prevention, care and cure depends upon the variety.

Just here I wish to make a digression and an appeal in one. It was really to attack the common practices upon the corn that this paper was conceived. I have seen medical men at the Turkish bath submit to an operation at the hands of the chiropodist and wince under a knife, which possessed the quality of being about as dirty as a knife could well be after having been used upon a series of feet of different kinds and then having the infective element rubbed even more thoroughly in upon a stone used for no one knows how long without ablution. So much for the hygiene, now for the practice itself.

A corn is essentially a growth of epidermis, due to pressure, and due to friction constantly kept up at the same point. Beginning as a small bit of cornification, or keratinzation, the

continued pressure starts a wedge-shaped tumor pressing inward, the pressure increasing with the outer thickening or broadening and thickening of the wedge. If the friction is removed the horny layer of the epidermis is gradually shed in successive layers and the corn gets well of itself. This logic conclusion appeals to many persons who suffer from corns and they change their shoemaker or wear a shoe of different shape for this purpose. When a corn persists, the treatment indicated is based upon Nature's way.

The barbarous foot doctor does the opposite thing, and cultivates the corn and at the same time his clientele. He dissects out the corn, exposing the sensitive papillæ of the corium, puts on a soft dressing, and allows the corn to form again, usually larger than before from the fresh irritation caused by the knife. In a few weeks the corn again gives annoyance, and the operation is repeated. This is so commonly the case that it is frequent to hear the remark that, ' So-and-So cuts my corns."

The logic care of the feet would prevent the necessity of a regular corn-doctor, as there would be no corns.

Begin first with the shoes, and have them to fit. Shoes too loose are as bad as shoes too tight. The same shoes should not be worn two days in succession. A little talcum powder in the stockings will prevent friction.

When corns form the treatment should be palliative and gentle. For the soft corn between the toes, ordinarily, gently greasing the toes well in the morning with some simple ointment and putting a film of cotton between will in a few days cause them to disappear. When there is much moisture a powder of salicylic acid, or resorcin, or thuja in 5 per cent. strength, mixed with compound stearate of zinc may be used instead of ointment. Rhubarb powder in 20 per cent. strength with arrowroot powder does well also.

For flat corns, not especially painful, the salicylic acid plaster (10 per cent.) is useful. It should be applied and left on for several days, renewing as it washes off in the bath. After three or four days the corn will be seen to grow white and soft, and usually may be rubbed off in washing. If not, then simple rubber adhesive plaster should be applied just as the other plaster, and should be kept on in the same way until the skin level is normal. This procedure may have to be persisted

in for several weeks, the alternating salicylic acid plaster and adhesive plaster being kept up until the skin has a normal level. This treatment accomplishes in a rapid way exactly what Nature does slowly. The salicylic acid softens and removes the horny epidermis and leaves the under layer of the epidermis (not the tender corium) exposed. The adhesive plaster protects the new epidermis until it has recovered from the former morbid condition.

This treatment may be modified and salicylic acid in collodion may be used instead. This is preferable where the corn is much elevated. At times the corn becomes inflamed, and even cystic. Then treatment must be a little different. Diachylon plaster can be kept applied, the corn being protected by a covering of cotton and collodion, until the inflammation is relieved, when a thorough soaking in water, to which starch and carbonate of soda have been added, will soften the corn sufficiently for the salicylic acid treatment to be begun.

A host of local applications are suggested for corns, but the above procedures have appealed to me as the best, and where the occasional patient has come under my care for the condition I have found the method full of success.

I have never felt that I offended my own dignity by treating corns, any more than I would in treating conditions considered more important. So soon as the medical man meets his patients with the attention they deserve in these and other *little* things, the field of the charlatan will just so soon grow so small as to be unprofitable, and therefore deserted.

Clinical Reports.

UNUSUAL BEHAVIOR OF CORNUAL PLACENTAL IMPLANTATION.

By J. G. BOUVIER, M. D., Jeanerette, La.

Mrs. B., aged 36, sextipara, personal history good. Had two miscarriages at four months, the last four years ago. Child born two years ago now living.

This patient consulted me for profuse menstruation. The periods would last from fifteen (15) to twenty (20) days; this loss of blood was accompanied by lumbar, sacral and ovarian pains, urethral irritability, gastric fermentation, constipation, mental depression and palpitation of the heart. During the few days between the periods there was a discharge of thick greenish mucus, containing many shreds of a whitish membrane. Physical examination revealed a cervix somewhat enlarged, and lacerated up to the corporeal junction. The body of the uterus was also enlarged, tender and almost immovably bound down in the pelvis. I diagnosed endometritis, puerperal subinvolution, plastic cellulitis and laceration of the cervix.

I advised negative intrauterin galvanism, to disorganize the exudate, and cause its absorption, and faradism from high tension coil to promote and equalize the circulation through the pelvic organs, then curettage and reparation of the cervical tear would effect a permanent cure. After two weeks electric treatment the exudate had become reabsorbed, the uterus was freely movable and no longer tender, but still a little enlarged and very much retroverted.

On June 29, assisted by Drs. M. B. Tarleton and G. A. Sigur, I performed the curettage and repaired the torn cervix. I wish to state here that in curetting I always adhere to the method of my instructors, Professors Goelet, Garrigues and Austin Flint, Jr. (of New York), also Professor Byford (Chicago), and that is to curet systematically, going twice over the surface. I go over the anterior surface, then over the posterior, and then over the sides, leaving the cornua and fundus for the last. I then wash out the uterin cavity with hot creolin solution. I curet the entire cavity as before and wash out with hot lysol solution, then, pack with steril gauze, which is usually removed in twenty-four hours. I was particularly anxious to cure this case, therefore did the work thoroughly and carefully.

The Emmett's operation was then completed by introducing five sutures of silk-worm gut. These sutures were removed on the twelfth day, perfect union having taken place. The patient menstruated naturally on July 12. After cessation of the menses she came to me for relief from the same pains in the pelvis. I found the pelvic organs bound down as before from plastic exudation. I told her that I thought I could cure her in

about five weeks. I began galvanic and faradic (intrauterin and abdominal) applications three times a week. As the exudate began to be reabsorbed, the patient complained of an uncomfortable, pulling sensation in the left side, where I noticed an enlargement, long and round, about the size and shape of a three-ounce prescription vial. I supposed this enlargement to be a hydrosalpinx, but gave no opinion. I had noticed for several days that the cervix was dilated large enough to admit the end of the finger, and when the electrode was introduced into the uterus, it (the electrode) would invariably land into the right cornu, while the left side seemed to be filled with a hard substance.

The intrauterin applications were kept up until September 13, when the patient was perfectly well, except that the uncomfortable falling sensation had given way to a severe stretching, teasing pain, and the swelling in the side had grown to twice its former size. I sent the patient home and told the husband that I did not know what the swelling was, but would decide in a day or two. I at once gave almost my entire time to the study of this case. I began at the beginning, went over all the symptoms already mentioned; I was certain that it could not be a pregnancy existing before the 29th of June, on account of the thorough curettage performed on that day. I was equally certain that impregnation did not take place after that day, because I am positively assured that my orders forbidding sexual intercourse were strictly adhered to. Besides, the appearance of the menses, no enlargement, tenderness or change of the breasts, no vomiting, no nausea, and no fetal movement. If these or any other symptoms indicative of pregnancy would have been present a woman who has been eight times pregnant should, it seems to me, have suspected pregnancy. That there was a swelling is true, but it was confined to one side and apart from the uterus, indicating a pathologic instead of a physiologic growth. So, after much worry and study, I concluded that my patient had an ovarian cyst, and coexistent with it a hydrosalpinx.

On September 17, I started to inform my patient of my opinion. When I had gone about two-thirds of the way, I was met by her son, who told me to come quickly, his mother was very sick. Arriving at the house I was informed that the woman had miscarried. And, sure enough, for lying between its

mother's thighs was what I called a three months fetus. I was informed by the woman in attendance that the after-birth had not yet come. The cord was five inches long, one end attached to fetus, while the placental end was not attached to anything. I introduced my hand into the uterus *and the after-birth was not there.* I asked the attendant if she had pulled on the cord, but she had not touched it. I began looking among the bed clothes for the after-birth but could not find it. By palpating I could make out the large flabby uterus, while to the left and just above it was a mass about the size and shape of two small ink bottles, with their bottoms to each other. I now introduced my left hand into the uterus and found a small opening, which I suppose was the entrance into the fallopian tube; the opening could easily be stretched to admit two fingers. I found attached a placenta which measured one by three inches; and which was removed with much difficulty. The woman in attendance informed me that the body had lived about half an hour.

The fetal head one hour after birth measured antero-posteriorly (occipito-frontal) two and one-half inches. The chest, antero-posteriorly, measured two inches. The fetus was doubled up like a "jack knife" and when fully extended measured eight inches in length.

Twelve hours after birth my attention was called to the great growth in size and length of the fetus; the flesh was firm; the bones of the head completely filled the scalp, and the general appearance very life like.

The fetus now measured in occipito-frontal diameter three and one-quarter inches; the expanding of the ribs now brought the chest diameter to three inches, and with the feet extended measured ten inches long.

By the large crop of hairs covering the scalp, the appearance of the eye brows and eye lashes, and the projecting of the free border of the nails from the underlying skin, I now recognized a six months fetus.

The mother made a good recovery and is now in excellent health.

A CASE OF RHINOPLASTY.

By G. H. LEE, M. D., Galveston, Texas.

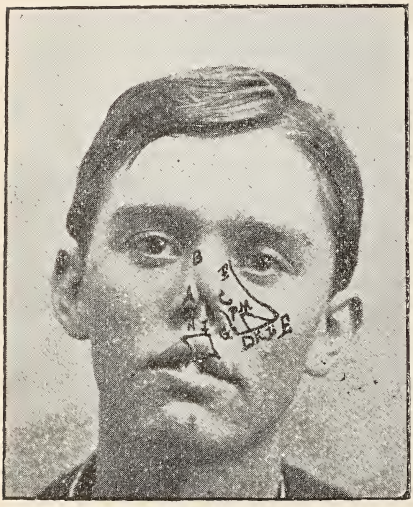
The following case is reported because of its rarity, with the consciousness that there is nothing original or especially new in the procedure, yet with the hope that it may be of interest.

Rufus C., age 19 years, was injured by the accidental discharge of a single-barreled shotgun, loaded with squirrel shot. At the time of the discharge, he was holding the gun in his hand by the barrel, and was in the act of placing the butt of the gun upon the ground, when the hammer struck a log—the load of shot grazing his chin, his lower lip, carrying away a piece of his upper lip and a large portion of his nose.

The resulting deformity, as shown in the photographs, consisted in a harelip of the second degree, and the loss of the lobe of the nose, almost the entire cartilaginous portion of the septum, including a small portion of the nasal bones in the median line, the cartilaginous part of the left ala up to the nasal bone, and on the right side a part of the cartilaginous portion of the ala, the remainder of the side being rolled under by the faulty union along a rent which had extended up the right side nearly to the inner canthus. The patient was a farmer's son, in excellent general health.

The harelip was repaired at one operation by making an incision beginning upon the right side at the margin of the cleft, extending upward and to the right to the vermilion border, prolonged thence a short distance to split the border. Thence it was carried close to the margin of the cicatricial tissue upward and to the left to nose and back down upon the left side of the cleft in the same way. The lip on each side was then freed from attachment to the alveolus and brought together with silkworm gut sutures. After firm union had taken place, which was very prompt, under a second chloroform anesthesia, the operation for repair of the nose was begun by opening up freely the old rent on the right side, and the mucous membrane of the right side of the septum was freely exposed by holding this flap back. The nasal fossa above and below was then tightly plugged with steril gauze to control hemorrhage, and an incision was made in the mucous membrane through to the bones of septum, and a flap dissected up, including the mucous membrane and periosteum and turned forward on its anterior attach-

ment, which was carefully preserved to supply the missing portion of the septum. The periosteum was carried over in the hope there might be some deposit of thin bone sufficient to give a stiffness to the new septum.





An incision was then made on the left cheek, beginning at the point C, and following the outline C. D. E. F. This flap was dissected up, including as much as possible of the fleshy tissues and slided over on to the position of the nose. A portion of this flap was then removed at K. I. M. for the opening to the nostril, the piece of tissue K. I. M. being trimmed down to the derma and placed in the triangular interval left, just below F., where it adhered perfectly, thus preventing any contraction at that point and the resulting drawing of the eye. The flap from the septum was then sutured with catgut to the under surface of the line C. D. K., sutures being arranged at about the point P., to bend this flap at a right angle and make a lobe for the nose. The right ala B. A. was unrolled and sutured to B. C. Some redundancy at B. from the sliding of the flap was trimmed off, the cutaneous tissue thus removed being also used to assist in covering the denuded area on the left cheek. D. K. was sutured to H. I., forming the columns L. E. to G., making the lower corner of the left nostril, and the side of the flap, E. F., sutured in its new position. Silk work gut and fine silver wire

were used for these sutures. The remaining denuded area on the left cheek was covered by skin grafts (Thiersch's method) from the left arm. Hemorrhage was profuse, as is usual in operations about the face. A drainage tube was kept in each nostril during process of healing. At a subsequent operation a number of ragged points were shaped up.

The result was a complete septum and a fairly respectable looking nose, as shown by the photograph, which was taken just a day after the last sutures were removed.

The method used in this case is modified after Langenbach.

Clinical Note.

FOR INGROWN TOE NAILS.

B. A. COLOMB, M. D., UNION P. O., LA.

Perhaps the following simple method of dealing with ingrown toe nail may be of interest to your readers: While freezing with ethyl-chloride spray, which the patient may apply, all tissue overlapping the nail is carefully cut away. The toe must be rounded off on the diseased side until the nail is free for some distance back. The edge of the nail is then trimmed with scissors. The wound should be dusted with aristol and a gauze dressing put on. Excessive granulations should be kept down with lunar caustic. The operation is painless, free from all danger, and the contraction of healing leaves the nail free.

Clinic Lectures.

Specially reported for the JOURNAL from the Philadelphia Clinics.

I.—ON THE TREATMENT OF GALL STONES.*

BY DR. F. P. HENRY.

The chief object of treatment of gall stones are, first, the relief of the paroxysm; and, second, the prevention of recur-

*From a lecture delivered at the Woman's Medical College.

rence. The first indication is promptly fulfilled by hypodermic injections of morphia. I have always found that this rendered the attack endurable. One-quarter grain is quite enough of the sulphate or acetate of morphia repeated once or oftener until the effect is produced. There are authorities who object to the use of the drug here, but I venture to say that each of these individuals would have used morphia on himself under the circumstances. Administered by the mouth in these cases morphia or any other preparation of opium seems to me almost inert; whether it is absorbed or not I do not pretend to say; I should think not, because it seems of no use. If you continue to give it, then, after the attack has passed off it may have its effects and the patient may die. If the pain continues severe after the administration of morphia, chloroform or ether may be given by inhalation, and if need be, the patient may be kept under this influence for hours, for it not only relieves pain, but it relaxes the muscles of the bile ducts and assists in the passage of the stone. An old method of treatment, one that has been lately revived, consisted in giving large quantities of olive oil, as much as a pint having been swallowed in one day. After taking this the feces will contain small waxy bodies which bear a resemblance to gall stones. They are really nothing but the result of changes in the oil ingested. Nevertheless there are reputable physicians who claim a large amount of benefit from this treatment, and as it is harmless, it may have a trial. It is given in amounts of four to six ounces in divided doses, an ounce at a time. This method is referred to Professor Donaldson, of Philadelphia, in 1842, but Europeans were claiming recently to have made the discovery. It is doubtful in my mind whether there is any efficacy in the method.

To prevent the recurrence of the attack, alkalies are administered. These are given preferably in the form of mineral waters, as Carlsbad water, which enjoys a reputation apparently resting on substantial facts. Salicylic acid and sodium salicylate are given in view of their known faculty of promoting the secretion of bile. The so-called "Durand's remedy" consists of sulphuric ether and oil of turpentine. It is very doubtful whether this exerts any solvent action on stones; whatever good it does may be ascribed to the properties of ether and turpentine in promoting the secretion of bile and increasing its fluidity.

The question of surgical interference comes next, with the operations of cholecystotomy and cholecystectomy. The statistics in regard to these operations are exceedingly favorable. I saw a woman once who had repeated attacks of hepatic colic and had made up her mind to have an operation performed; but she had no further attack and the operation was not performed! Do not leave your operation too long, or all the stones will have passed out.

In another case, where Dr. Osler had made the diagnosis, an operation for impacted calculus was performed. The calculus was not found; the patient died and was buried in the near neighborhood. Dr. Osler was so positive that the calculus was there that he obtained the body, made a search and found the calculus impacted in the hepatic duct. His diagnosis was right and the surgeon had failed to find the stone.

II.—TREATMENT OF SYPHILITIC ULCERATION OF LARYNX AND ACUTE EDEMA OF THE GLOTTIS.*

BY DR. EMMA E. MUSSON.

The main difficulty in cases of laryngeal phthisis is the very painful swallowing. The best way is to have the patient lie down and be drawn to the edge of the bed so the head will hang a little over. Then have your patient take the liquid food through a glass tube. In that position the cricoid will not press so against the pharynx, and there will be much less pain on swallowing; a 5 per cent. solution of cocain may be used first.

Syphilitic Ulceration.—Primary and secondary manifestations here are rare and unimportant. In tertiary syphilis, ulceration is one of the late manifestations of the disease, and may occur twenty to thirty years after infection. In its first stage the gummatous deposit breaks down so rapidly that it is rarely seen. Then ulceration is followed by a cicatricial contraction or a deposit which narrows the lumen of the larynx. The voice becomes hoarse and very characteristic. There is profuse expectoration, sometimes bloody, and there may be edema and dyspnea, necessitating tracheotomy.

---

*From a lecture at the Woman's Hospital.

A case was brought to my office by a physician who said the patient was suffering from asthma. When the man came in he was almost purple, and examination of the larynx showed marked infiltration and almost absolute stenosis. In a second or two the man fell unconscious to the floor, from asphixia. We performed a tracheotomy, but in a few days the man died. I simply tell this to show that these cases are your cases as general practitioners.

The treatment is, of course, anti-syphilitic, the rapid administration of potassium iodide and mercury by the mouth, hypodermically, and, if need be, by venesection, and I need not enter into the details of this treatment. Of course the question of tracheotomy comes up frequently.

In treating locally, first spray downward directly with peroxide of hydrogen. Having removed thus all secretion, if there is ulceration you may apply lactic acid, beginning with the 20 per cent. and increasing to 100 per cent. solution. Other cases may do better with silver nitrate. Use the acid once a week, or once in two weeks, and in the meantime you can blow in a little simple powder.

Acute edema of the glottis is a rare affection, and except when of traumatic origin, is secondary. It is a good rule that when the infraglottic region is involved, the prominent symptom is dyspnea; when the vocal cords themselves are involved, hoarseness; and when it is above the glottis, cough.

In the first stage of infection of the larynx, cold compresses are of importance in the treatment, and hot inhalations. For the treatment of acute laryngeal inflammation you may use the following:

Menthol, gr. v, or chloroform	gtt. j.
Tr. opii. camph	f. ℥ ss.
Tr. benzoin comp., q. s. ad	f. ℥ ij.

M. Sig. One teaspoonful in a pint of hot water, for inhalation.

Also, in all those cases of acute laryngeal infection, an even temperature of at least 74 deg. is important, and the atmosphere should be constantly moist. This may be effected by a small alcohol stove in the room, constantly throwing off vapors of drugs—terebene and creosote are my favorites. Direct manipulation is of course impossible. It sets up inflammation, and may bring on an attack of dyspnea. If the edema is marked

and localized, the knife must be used, and this is not very difficult. The larynx is first thoroughly cocainized with a solution running up to 20 per cent. Then, with your mirrors in place you puncture with the small curved knife. Relief follows almost immediately, and there is no excuse for not puncturing these cases, for if not you may soon have to resort to tracheotomy.

Charity Hospital Notes.

Specially Reported for the JOURNAL.

HYPERTROPHY OF THE VULVA; OPERATION.

CASE OF DR. HAMILTON P. JONES, M. D., ASSISTANT TO THE CHAIR OF MINOR AND CLINICAL SURGERY IN THE NEW ORLEANS POLYCLINIC, NEW ORLEANS.

L. S., a negress, aged 30, first came to the outdoor clinic during the month of May. At that time she presented a mass about the size of a cocoanut. She says she first noticed the enlargement about a year ago, which began with hypertrophy of the major labia. When patient was first seen there was no ulceration or sloughing, and the mass was troublesome only mechanically. She was admitted to Ward No. 36, where she remained for the space of two months, during which time the growth steadily increased in size. At the end of this time patient left the hospital for about two weeks, and when she returned the growth presented the appearance shown in the photograph. Extensive ulceration and sloughing had taken place, and active infection was apparent. Necrotic tissue was most abundant in dependent portions and toward the anal region. Examination of urine showed .75 per cent. of albumin. She was prepared for operation, and on August 11 the entire mass was amputated and the ulcerated area about the anus cauterized with the actual cautery. Hemorrhage was very troublesome during the operation, necessitating clamping and ligation of many vessels. Retention sutures were inserted to assist healing, and the wound dressed. On account of the badly infected condition of the site of operation consequent infection of the wound was unavoidable, and suppuration took place.

Having become unruly she had to be discharged from the hospital—August 22. At that time the wound was healing; suppuration was subsiding, and vulva presented nearly normal appearance.

Microscopic examination of the tumor revealed simple overgrowth of connective tissue.



Hypertrophy of the Vulva: Illustrating Dr. Jones' Case.

A CASE OF COMATOSE MALARIA, WITH CHRONIC ENDOCARDITIS.

Case of Dr. P. L. CUSACHS, Visiting Physician to Charity Hospital, New Orleans.

S. H., aged 48 years, colored, native of Louisiana, was admitted to ward 31 on the evening of October 19, giving a history of having had chills and fever daily for over one week. On the morning of the 20th, between 4 and 6 o'clock, patient became

comatose. At 6 A. M. the temperature was 102 deg., respirations 22, pulse 82. Ten grains of the bisulphate of quinin were administered hypodermically at 10 A. M. of the same day, and repeated at intervals of two hours until 30 grains had been given. The urin was drawn by catheter and examined, but nothing was detected pointing to nephritis. Blood examination revealed malarial plasmodia in abundance. At 6 P. M. the temperature had dropped to 98.8 deg., respirations 20, pulse 64. Ten grains of the bisulphate was again given at 6:45 and 10 P. M. On the morning of the 21st the coma had become more profound, and the temperature had again risen to 102 deg., respirations 24, pulse 100. The quinin was continued as on the previous day; a hot salin enema was given, together with 5 grains of calomel and soda per orem, which produced a free evacuation at 6 P. M. The patient remained in deep coma, with a temperature of 99 deg., while the respirations remained 24, pulse 74. The morning of the 22d found the comatose condition unaltered; stertorous breathing was marked. Quinin bisulphate had been given as before at 1 and 3 A. M. The temperature had now fallen to 97.2 deg., while the respiratory rate remained at 24, pulse 80, and rather full. Strychnin sulphate, 1-30 of gr., was given hypodermically every four hours during the day; the hot salin enema being repeated at 2 and 6 P. M. The patient died at 7:30 P. M. of this day.

Post mortem examination showed enlarged, very mushy, slate colored spleen, which weighed 12¾ ounces. Evidences of chronic endocarditis were also present.

IN EVIDENCE.—"I presume you carry a memento of some kind in that locket of yours?" "Precisely; it is a lock of my husband's hair." "But your husband is still alive." "Yes; but his hair is all gone."—*Ex.*

POST HOC.—Doctor: "Oh, well, influenza in itself isn't so terrible, but it is liable to be followed by terrible consequences."

The Patient: "Yes, I've noticed that before in your bill."—*Ex.*

N. O. Medical and Surgical Journal.

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

YULE TIDE.

"I heard the bells on Christmas Day
Their old familiar carols play.
And wild and sweet
The words repeat
Of peace on earth, good will to men."

—*Longfellow.*

In the hurly burly of a restless, active life, it seems good to stop even for a day, to grow reflective, and live in the atmosphere of mystic superstition and holiday. Christmas always brings the thought of rest as it brings the thought of joy; each carrying a grain of sadness for its shadow.

The Christian races all blossom out in charity and soul thoughts on this day and each year the world grows more full of its celebration and each year more elaborately. Even the lowly find a bit of pine tree, a streak of tinsel and a candle to pay tribute to a heathen rite, all brought subservient to the dominant Christian idea and all emblems of "the Peace on Earth, Good Will to Men."

THE TEXAS MEDICAL PRACTICE LAW.

We have from time to time tried to express our sympathy in the effort of the Texas profession to obtain adequate recognition of the public's need for protection in medical ways, various and sundry. It is now a good quarter of a century that the best of the Texas medical men have fought for better lines of

restriction in the right to practice in that State. In the front line of the fight, several men have now some time passed to the beyond, leaving behind as a heritage the right to champion the correction of the existing evils.

From year to year each Texas Legislature is memorialized, and is besought by direct and indirect petition and personal argument at the hands of the officers and of the rank and file of the Texas State Medical Association.

After years of striving a flimsy law, recognizing diplomas and abolishing district or county examinations, has come forth. Its very existence as it stands is an insult to the educational standard of the Galveston school, the school of the University of Texas; its very clauses permit the planting of bastard schools, created to abuse the law, in the face of the standard school of the State, while the profession itself suffers by having a burden of ill-conditioned parasites thrust upon it.

Louisiana has passed through the experience, and the protection we now enjoy all the more keenly demonstrates Texas' need. The obtuseness of the solons in the Texas Legislature seems almost impossible in this day of enlightenment and progress, but the leaven has been long at work, and must, in time, be productive of the natural and logical result.

SEPARATE ACCOMMODATION FOR CONSUMPTIVES.

In a paper presented to the Medical Association of the State of Alabama and published in the *Alabama Medical Journal*, Dr. W. H. Blake forcibly calls attention to the need of separate prisons for consumptive convicts. To-day, that the cause and method of propagation of tuberculosis are so much better known and appreciated, not only by the profession but by the well-informed public, Dr. Blake's plea should be heeded by the authorities of his State; it indicates one line on which should be waged the war against the universal disease, a difficult and tedious war, the first skirmishes of which only are now being fought.

Prisoners of all descriptions are more susceptible to disease, and particularly to tuberculosis, hence they should not directly and persistently be exposed to the latter. No matter what their

crimes or how deserving of imprisonment and punishment, the State has no right wilfully to expose them to disease when it is so easily to be avoided. It would not usually be necessary to establish separate prisons, but separate departments or sections could be provided for the tuberculous without detriment to themselves and much to the advantage of the healthy.

We are not the least in sympathy with any mawkish sentiment which tends to give to criminals more and better than to the honest in the same station of life, but we are opposed to making them uselessly run risks which are not taken into account in their punishment. Besides, it is not for their sake alone; every prisoner who is set at liberty after having contracted consumption becomes an added menace to the health of the community and the world at large.

If the above is true, it is applicable with all the more force to boarding schools, convents, and seminaries—in short, all establishments where numbers of people congregate closely and for many hours daily, especially in dormitories.

THE THIRD PAN-AMERICAN MEDICAL CONGRESS.

The congress is to take place in Havana, Cuba, December 26 to 29 of this year. Very little has been announced in relation thereto, but the occasion will no doubt prove an interesting one medically and scientifically, while affording a splendid occasion for an agreeable visit to the "Pearl of the Antilles."

The Southern Pacific Company (Morgan Line) offer a round trip rate of $50, including berth and meals on the steamer. The latter leaves New Orleans December 17 and 22, returning as early as December 31, to arrive here January 3. We hope a good number will avail themselves of this opportunity.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

Traumatic Dislocation of the Face.—Mr. Delbet, in *Semaine Médicale*, October 24, 1900, relates a case of traumatic dislocation of the face. He found only one similar case in medical literature.

A carpenter, 25 years of age, fell from the top of a scaffold. During the fall his face, looking forward and downwards, struck a cross-bar, the angle of which imbedded itself in the naso-frontal depression; simultaneously a beam struck him on the occiput.

Instantly the wounded man became unconscious. When he revived, he was speechless. The next day he presented an enormous swelling on both cheeks, the root of the nose, and the eyelids, with an ecchymotic spot at the base of the nose and a large sub-conjunctival ecchymosis on the left side.

Notwithstanding a constant sero-sanguineous discharge from the nares, as the patient is calm, speaks fluently and intelligibly, no cerebral symptom being present, the diagnosis of simple contusion of the face, with probable fracture of the nasal bones, was made.

The following day, the patient being improved, an attempt was made to feed him, but he could not chew, every movement of the maxilla being painful, so that he had to be nourished exclusively on eggs and milk. The patient improved daily, but as the inability to masticate persisted, a thorough examination was made ten days later, with the following result: The exaggerated dimensions of the face in relation to the cranium were evident; the nose was elongated, the eyelashes directed obliquely downwards and inwards, the internal angle of the eye being much lowered. On the other hand, when the patient opened

his mouth to the maximum, the space between the two dental arcades did not exceed three to four milimetres, and it was easily seen that the inferior maxilla could not be further lowered; nevertheless, the superior dental arcade was easily pushed upwards, causing thereby the whole face to meet the forehead. Palpation revealed an interval about four centimetres between the nasal notch of the frontal bone and the upper part of the nasal bones, and with the finger in the mouth, the pterygoid processes were felt movable with the superior maxilla.

There existed in reality a huge osseous mass totally dislocated downwards, comprising, besides the superior maxilla, the two malar bones, the nasal bones, the palatines, the pterygoid processes, the vomer and a part of the ethmoid. Such a displacement could certainly not occur without fractures, which, according to Mr. Delbet, involved the vertical and the cribriform plate of the ethmoid, the base of the pterygoid processes and, no doubt, the zygomatic arch.

This extraordinary dislocation was certainly caused by the following mechanism: The occipital shock drove the cranium forwards whilst the face was wedged by the plank imbedded in the nasal frontal angle. Such singular circumstances fully explain the rarity of such a lesion.

Local Anesthesia by Subcutaneous Injection of Hydrogen Peroxide.—Dr. H. E. Kendall, of South Sydney, in *Semaine Médicale*, November 7, 1900, states that a local anesthesia, sufficient to perform minor operations, can be induced by hypodermic injections of oxygenated water. The Doctor, by these means, was enabled to incise abscesses, and even open the pleura and peritoneum without pain.

The analgesic effect of peroxide of hydrogen is not due to the absorption of the injected fluid, as one would suppose, but to the tension caused by the abundant liberation of the gas in the subcutaneous cellular tissue, the injected zone becoming as hard as frozen tissue.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans, La.

The Prevention and Treatment of Post-Partum Hemorrhage.—Dr. John W. Byers contributed a valuable paper on this subject at the last meeting of the British Medical Association. In outlining the plan of treatment of post-partum hemorrhage after the placenta is entirely removed, he states that external uterin massage should be the first measure. Should this plan fail, then hot water should be used. A double current instrument is preferred, and it is a great advantage at the same time to draw down the uterus by catching the anterior lip of the cervix with volsella forceps. The water should be used at about 118 deg. F., and in large quantities. No antiseptic is necessary; he prefers salt solution, and advises against corrosives at any time. Cold water should not be employed; it is not steril, and has prejudicial effect on the anemia. The hand should never be passed into the uterus except when the indications are clear. Bimanual compression is very fatiguing to the accoucheur and trying to the patient. Gauze plugging of the uterus is advised. Great care should be taken to plug the uterus tightly to the fundus.

Volsella forceps can hardly be dispensed with when plugging the uterus. Should a case be met with where, notwithstanding the gauze packing, hemorrhage continues, the gauzes should be renewed after washing the cavity. If, then, the hemorrhage continues, the uterus should be firmly drawn down by volsella forceps or tenacula passed through its lips. This method acts by kinking and compressing the uterin arteries, as seen in vaginal hysterectomy. In such cases Schauta, of Vienna, thinks atheromatous vessells are present in the placental area. Schauta advises laparotomy in hospital practice, or in private practice eversion of the uterus by pressure on the fundus, so that the bleeding vessels may be caught. When the bleeding ceases the uterus is reinverted (Byers does not recommend this; he mentions it on authority of Schauta). Injections of iron solution

are not without danger; it causes a certain amount of injury to the uterin wall. Gauze plugging has replaced iron in bad cases in the Rotunda Maternity Hospital.

Observations on the Obstetric Surgery of Pelvic Contraction.—In discussing the methods of delivery in pelvic contraction, Dr. Charles Jewett (*Brooklyn Medical Journal*) states that spontaneous delivery occurred in 60.7 per cent. of the cases in his service. Such figures serve to emphasize the importance of withholding intervention so long as there is a reasonable doubt that the labor may be terminated safely by natural forces. With efficient pains, apparently impassable obstruction sometimes may be overcome by extreme moulding of the head.

Craniotomy had not been practiced on the living child in his service, though he believed in rare instances the sacrificial operation is better than its alternatives. In extreme exhaustion of the mother the interests of the child should not have too much weight. This is particularly true in private practice.

Induction of premature labor had not been performed owing to the cases having come under observation in the last weeks of pregnancy. When the period for such an operation is very limited the interests of the child are to be considered. To offer a fair chance of success the time must be about the thirty-fifth week and the conjugata vera not below 3¼ inches, or at the lowest 3 inches. At best the fetal mortality is high from prematurity after birth, being reported at from 20 to 38 per cent. Yet Tarnier, commenting on his own results in 116 cases of induced labor, in which none of the mothers died and twenty-six children were lost, pertinently observes that it is better to save 100 mothers in 100 labors, with a loss of twenty infants, than to lose 8 per cent. of the women and 10 per cent. of the children by Cesarean section.

Symphysiotomy has not replaced Cesarean section in relative contraction, and experience has restricted its scope within narrower limits since its recent general revival.

The gain in the conjugate can not exceed a half inch consistently with the safety of the sacro-iliac joints. The operation compares unfavorably with Cesarean section in that it does not effect delivery, but merely prepares the way for it. Finally, the after care is complicated and difficult. Dr. Jewett believes

the injuries to the soft parts and imperfect union is preventable. He disagrees with those who think the operation has not justified its existence. It offers a fair chance in the presence of considerable exhaustion, a condition in which Cesarean section is attended with very high mortality. It is also applicable in minor cases of narrowing too slight to justify section primarily, yet in which nature and forceps have failed. In cases where very little additional space is required for delivery it offers a means of saving the child, which is less formidable than abdominal section. The opinion that the pelvis remains permanently larger after symphysiotomy appears to have no foundation in fact.

The best results in Cesarean section have been those of elective operations.

The advantage of operating before the exhaustion of labor, and at a prearranged time, are apparent. Yet, operation in advance of labor is not universally accepted. Against it is urged the risk of hemorrhage from failure of uterin contraction. There is no proof that the complication is due to antepartal deliveries, because atony is sometimes encountered after spontaneous deliveries. A much discussed question is what to do with the uterus. The chief cause of mortality in the conservative operation is infection, springing from the uterin cavity. In certain conditions the necessity of hysterectony admits of no question. All are agreed that the uterus must be removed in the event of probable infection, *e. g.* gonorrhea, acute and chronic. In such cases failure of union and leakage is likely to follow. Persistent atony of the uterus is also an indication for the removal. The comparative results of hysterectony and Cesarean section are not yet determined. Theoretically the radical operation should be better. The ethic question must, of course, be considered. Except when demanded in the interest of her life, the surgeon can not assume the right to sterilize the woman without her consent.

The Intra-uterin use of the Rubber Balloon in Obstetrics—Dr. Rubeska of Prague contributes to *Obstetrics* (September, 1900) his views as to the indications for the intra-uterin use of the rubber balloon in obstetrics. It is, in his opinion, one of the most beneficent of recent achievements in practical

obstetrics, and deserves to become the common property of physicians.

Since 1894, it has been used by him for the following purposes:

(1) The induction and acceleration of abortion; (2) The induction of premature labor; (3) To take the place of the ruptured amniotic sac in premature rupture of the membrane; (4) To strengthen uterin contractions; (5) To hasten delivery in the presence of danger to mother or child, or both.

Braun's colporynteur and the bag of Champetier were preferred. The walls should be of extra strength, also the inelastic variety, interlaid with cotton material, and were used usually without traction, though in urgent cases traction should be employed.

A number of cases of abortion are related in which the effect of the colporynteur was strikingly apparent in every case. Uterin contractions were excited, sufficient dilatation secured and the ovum expelled very readily.

Small bags filled with from 200 to 400 *c.cm.* were used; contractions are aroused and the cervical canal much more certainly and effectively than by solid dilators, or gauze tamponade. The operation is much simpler and safer and is to be preferred to either of these methods. As a means of inducing *premature labor* it has great advantages over the usually employed methods, chief among which is the time necessary to complete the case. Prior to the end of 1899, this method had been employed in the clinic in forty-five cases with an average duration of 36.9 hours. The longest period before delivery was eight days in one case, the shortest five hours. It has been found that the period can be further shortened by employing an inelastic bag and adding a traction weight. This method was eminently successful in two cases where the ordinary use of bougies had failed after eight days in one case, in eighteen in another. Thorough cleaning of the vagina must be insisted upon. If the canal is not patulous, it is dilated by tents or bougies sufficient to permit of the introduction of the bag. The bag is introduced and left until expelled by the pains. If pains are not excited the bag may be weighted. There was no material mortality. The fetal mortality compares favorably with that following the use of other methods.

A further important indication for hysteranesis is found in dry labor, especially in cases of pelvic contraction, when the cervix dilates slowly, the contractions become abnormally painful and the amniotic fluid is completely drained away. Forceps operations in such cases are most difficult and bloody. By means of the rubber balloon the amniotic sac is replaced, the cervix dilated and the contraction quickly strengthened, thus making many high forceps operations unnecessary, and children saved that would otherwise be lost. The balloon will also take the place of deep cervical incisions.

In uterin inertia, especially when due to premature rupture of membranes, the pains were strengthened in every instance. The method is to be regarded as the only real oxytoxic.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Practical Points on Muco-membranous Colitis.—Before anything else, let us recall a few up-to-date facts on the subject. Characterized by the passage in the stools of flakes and shreds of mucus, at times of mucous casts of the lining of the colon resembling tapeworm, or macaroni (Thompson of N. Y.), this chronic disease of the colon presents two distinct forms (Boas of Berlin; Jusius Mannaberg of Vienna), viz: membranous enteritis and mucous colitis. The former a catarrhal inflammation, with pathologic changes, the second a secretory neurosis without injury to the surface, paroxystic and neurotic in character. In both forms we have to deal chiefly with constipation and colic, often as a sequence, with auto-intoxication, anemia, emaciation, and occasionally with complications such as febrile dysenteric exacerbations and hemorrhage (Mathieu, of Paris).

Constipation might be the cause as well as the result of the disease, but in either case it must be remedied, and if it is, then only is there any hopes of curing muco-membranous colitis.

Castor oil and copious intestinal irrigations are most useful. Give castor oil in small doses (one teaspoonful to one table spoonful) with the first food taken in the morning early (milk, tea or coffee), on alternating days, with copious enemata. For these use 1½ or 2½ quarts of water at about 40 deg. C, or 104 deg. F., injected at a low pressure and slowly; the water may be simply boiled, but it is better to add some weak antiseptic solution of borax, sodium salicylate, or neutral ichthyolate of ammonium, the latter acting favorably on the catarrhal condition of the colon. Sweet oil can be used instead of water, alternately. These enemata not only relieve the colon of accumulated fecal masses, but lessen its painful irritation and spasm, while they act also as a mechanic antiseptic. Avoid all that could irritate the colon, such as drastic cathartics, astringent rectal injections (tannin), massage, etc. Even the usual constipation diet, viz., food which contains a relatively large proportion of waste indigestible material (fresh, more particularly green, vegetables, fruits, brown bread, etc.), might promote, in some cases, irritation of the digestive mucosa. Rather than irritate the bowels give them food that favors constipation.

For the attacks of colic the use of belladonna is attended with the happiest results. It relieves the pain and lessens the tendency to spasm. Opium, although it can be used, is not so often called for. Hot applications over the bowels and warm full baths are most useful. The well-known Plombière's cure, and that of other similar Spas, are based upon the action of prolonged warm baths and copious warm water enemata. Anemia and emaciation are met with proper nutritive diet, properly regulated as to the digestive condition of each individual. Dysenteric exacerbation is met with irrigations of weak nitrate of silver solution; hemorrhage with hamamelis and copious irrigations at a temperature of 45 deg. C., or 113 deg. F. For the nervousness which usually accompanies mucous colitis, sedative and anti-spasmodic remedies (Hoffman's anodyne, chloroform water, aromatic ammonia) and hydrotherapy are to be prescribed. —*L'Union Mèdicale du Canada*, September, 1900.

Smith's Signs.—In children, enlargement of the bronchial glands (often the seat of tubercle and of calcareous deposits) can be detected by both percussion and auscultation over the

manubrium of the sternum). By percussion, is elicited a more or less extensive dullness according to the size of the glands and by auscultation is obtained a venous *blowing sound, when the child's head is thrown well backward, thoroughly extended, face looking directly up.* The sound disappears, when the head is brought again to the normal position. Smith gives the following explanation: When the head is thrown back as said, the trachea with the glands around its bifurcation is brought upward and somewhat forward, and the left innominate vein which runs transversely behind the manubrium is caught and pressed between the hypertrophied glands and the sternum, hence the venous blowing sound.

A few points are to be remembered. First of all, for producing the sign the swollen glands must be free, since adhesions would prevent their moving upward with the trachea when the head is thrown back. Before proceeding to investigate the sign make sure that no abnormal bruit is audible over the manubrium when the head is in the normal position. In the majority of cases, the sign is clear and distinct, yet at times it requires close attention to detect it. At first, the murmur might be attributed to respiration, the trachea, it is thought, being apparently compressed as a result of the head's extended attitude. But, on the one hand, if the child is old enough it can be made to hold its breath, while, on the other, if the child will not hold its breath, the venous murmur, in both instances, can be differentiated from the respiratory sound by the fact that the former is continuous, the latter periodic. From what has just now been said, in children suffering from dyspnea and adenoid growths it is indeed obviously difficult to detect Smith's sign. Finally, it might happen that the murmur is not elicited immediately, it is a rule to auscultate for a while.

Smith's sign has been studied and verified by Hutmel, LeGendre, Andy and Brudzinski. It is a most useful sign, since the proper treatment of adenopathy can be started, at a very early date, a fact which is obviously important.—*Journal de Médicine et de Chirurgie pratiques*, October 25, 1900.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

The Relation of Ethyl Alcohol to the Nutrition of the Animal Body.—An interesting article is contributed by Hall to the *Journal of the American Medical Association* of July 14, 1900. In closing his paper he says that it is interesting to set over against each other, in parallel columns, some of the demonstrated facts which we possess regarding alcohol and food in their relation to nutrition.

The Truth About Alcohol.	The Truth About Food.
1. A certain quantity will produce a certain effect at first, but it requires more and more to produce the same effect when the drug is used habitually.	1. A certain quantity will produce a certain effect at first, and the same quantity will always produce the same effect in the healthy body.
2. When used habitually it is likely to induce an uncontrollable desire for more, in ever-increasing amounts.	2. The habitual use of food never induces an uncontrollable desire for it in ever-increasing amounts.
3. After its habitual use a sudden total abstinence is likely to cause a serious derangement of the central nervous system.	3. After its habitual use a sudden total abstinence never causes any derangement of the central nervous system.
4. Alcohol is oxidized rapidly in the body.	4. All foods are oxidized slowly in the body.
5. Alcohol not being useful, is not stored in the body.	5. All foods, being useful, are stored in the body.
6. Alcohol is a product of decomposition of food in the presence of a scarcity of oxygen.	6. All foods are the products of constructive activity of protoplasm in the presence of abundant oxygen.
7. Alcohol is an excretion and, in common with all excretions, is poisonous. It may be beneficial in certain phases of disease, but it is never beneficial to the healthy body.	7. All foods are formed by nature for nourishment, and are by nature wholesome and always beneficial to to the healthy body, though they may injure the body in certain phases of disease.
8. The use of alcohol, in common with narcotics in general, is followed by a reaction.	8. The use of food is followed by no reaction.

Alcohol.	Food.
9. The use of alcohol is followed by a decrease in the activity of the muscle cells and the brain cells.	9. The use of food is followed by an increased activity in the muscle cells and brain cells.
10. The use of alcohol is followed by a decrease in the secretion of $C O_2$.	10. The use of food is followed by an increase in the $C O_2$.
11. The use of alcohol is followed by an accumulation of fat through decreased activity.	11. The use of food may be followed by accumulation of fat, notwithstanding increased activity.
12. The use of alcohol is followed by a fall in body temperature.	12. The use of food is followed by a rise in body temperature.
13. The use of alcohol weakens and unsteadies the muscles.	13. The use of food strengthens and steadies the muscles.
14. The use of alcohol makes the brain less active and accurate.	14. The use of food makes the brain more active and accurate.

Apropos to the above the following is quoted from an editorial in *The Therapeutic Gazette:* "We have in previous issues of the *Gazette* expressed our view as to the value of alcohol in the treatment of disease, and we still believe that properly used as to dose, individual, and opportunity, it is like many other drugs, of great power or infinite value; and on the other hand, that if it is abused it is capable, just as digitalis and opium are capable, when wrongly employed, of doing a vast amount of harm.

"In the case of figures, statistics, and the statement of definitely ascertained facts with narrow limitations, there can be no doubt that the so-called deadly parallel column has very distinct advantages. But in the discussion of a subject in which so many collateral facts must be stated of greater or less importance, it does not seem to us that the parallel column should be used as it is in this instance (Dr. Hall). For example, it will be seen under the heading of '*Food*' that the first section states that a certain quantity will produce a certain effect at first, and the same quantity will always produce the same effect in the healthy body. With this dogmatic assertion we can certainly take issue, even when it deals with so simple a substance as a foodstuff. If the following assertions are read, we think that nearly every one of them can be objected to on very much the same grounds, and many of the statements in regard to alcohol seem to us to be equally open to criticism. Thus, statement 7 in regard to alcohol, namely, that it is an excretion, and in common with all excretions is poisonous, seems to us to be

contradicted by the remainder of this paragraph, in which it is stated that it may be beneficial in certain phases of disease, but it is never beneficial in the healthy body. If alcohol is an excretion and is poisonous, we do not see how it can ever be beneficial in certain phases of disease. We are taking issue with these statements not because we wish to assume the attitude of a carping critic, but because we think it important that in the discussion of such a nice subject as the one before us, false impressions may be produced not only in the minds of physicians, but also in the minds of the laity. And we can readily understand how persons who are biased in regard to the use of alcohol might quote these parallel columns accurately, and yet give them a far greater importance and weight than perhaps even their author would be inclined to do.

"The fact remains that thousands of physicians regard alcohol as being an exceedingly valuable remedy in certain conditions of disease, not only because they have been taught this, but also because experience from year to year has confirmed them in their belief, on the principle that the 'proof of the pudding is in the eating.' Of course there are certain moral questions which must be met in connection with this subject which it is not our intention to discuss, and it is also certainly a fact that alcohol is entirely unnecessary to the healthy, except perhaps at certain times when by reason of exhaustion, or other conditions, it is desirable to temporarily produce what we call stimulation."

Intermittent Fever—

℞ Cinchonin sulphate ..... 30 grm.
Fowler's solution ..... 90 min.
Tincture iron chloride ..... 4 fl. dr.
Syrup ginger ..... 12 fl. dr.
Distilled water to make ..... 4 fl. oz

Dessertspoonful after meals.

—Tutt, *Jour. Amer. Med. Asso.*

Malaria—

℞ Methylen blue ..... 15 grn.
Distilled water ..... 150 min.

Inject hypodermically 16 minims.

—Parenski, *N. Y. Med. Journal.*

PERNICIOUS MALARIA—

℞ Quinin hydrochlorate ..... 15 grn.
Sodium chloride ..... 1 grn.
Distilled water ..... 150 min.
Inject intravenously.

—SHORT, *S. W. Med. Rec.*

MALARIAL FEVER—

℞ Quinin sulphate ..... 90 grn.
Arsenious acid ..... 1 grn.
Acetanilid ..... 1 dr.
Make 30 capsules and give four during each twenty-four hours.

—DELAFIELD, *Tri-State Med. Jour. and Pract.*

ANASARCA OF MALARIAL ORIGIN—

℞ Compound spirits juniper ..... 1 pint.
Iron sulphate ..... 2 dr.
Potassium acetate ..... 4 dr.
Fl. extract digitalis ..... 2 fl. dr.
Syrup squills ..... 4 fl. dr.
Tablespoonful three times a day.

—MULLONE, *Jour. Amer. Med. Asso.*

TYPHOID FEVER—

(1) ℞ Formaldehyde (40 per cent. sol.) ..... 30 drops.
Elixir lactopeptin ..... 4 fl. oz.
Teaspoonful every one to three hours according to the severity of the case.

—LIND, *St. Louis Med. Era.*

(2) ℞ Creosote carbonate ..... 19 dr.
Thymol ..... 6 dr.
Menthol ..... 3 dr.
Eucalyptol ..... 390 min.
Alcohol ..... to make 8 fl. oz.

This to be used as a stock solution for the preparation of the following:

Compound solution creosote carbonate ..... 5 fl. dr.
Powdered acacia ..... 90 grn.
Water ..... 4 fl. oz.
Teaspoonful every three hours in a wineglass of water, followed by a drink of water.

—SIMMONS, *Virg. Med. Semi-Month.*

(3) ℞ Rect. oil turpentine ..... 1 fl. dr.
Spirits juniper ..... 30 min.
Fl. extract hamamelis ..... 2 fl. oz.
Powdered acacia ..... 12 dr.
Water ..... to make 6 fl. oz.
Dessertspoonful every four hours while awake.

—CHRISTISON, *New Eng. Med. Monthly.*

ASTHMA:

℞ Codein sulphate ..... 2 grn.
Wine antimony ..... 11 min.
Aromatic spirit ammonia ..... 1 fl. dr.
Comp. spirits ether ..... 4 fl. dr.
Peppermint water ..... to make 2 fl. oz.

Two teaspoonfuls as required.

—*Louisville Med. Monthly.*

℞ Potassium iodide ..... 3 dr.
Fluid extract belladonna ..... 1 fl. dr.
Fluid extract lobelia ..... 2 fl. dr.
Fluid extract grindelia ..... 4 fl. dr.
Glycerin .. } ..... of each 12 fl. dr.
Distilled water }

Teaspoonful every two to four hours, as necessary.

—BARTHOLOW, *Atlanta Med. and Surg. Journal.*

Department of Ear, Nose and Throat.

In charge of DR. A. W. DEROALDES and DR. GORDON KING, New Orleans.

A NEW METHOD FOR CURETTAGE OF THE ATTIC OF THE TYMPANUM AND REMOVAL OF THE OSSICLES IN CHRONIC MIDDLE EAR SUPPURATION.—Vacher, of Orleans, France, describes, in the October number of the *Annales des Maladies de l'Oreille, du Larynx*, etc., a method adopted by him for gaining access to the tympanic cavity and attic without the external incision and the displacement of the auricle, as is done for the Stacke operation. His plan is to make two horizontal incisions, an anterior and a posterior, from the inner extremity of the membranous canal out to the concha. This divides the auditory canal into two segments or flaps. Leaving the inferior flap thus made intact, he detaches the superior half of the membranous canal and turns it back and out over the internal face of the pavilion, where it is held out of the way by means of a retractor or a large ear speculum. The upper half of the osseous canal is left exposed, and the overhanging wall may be removed with a gouge or chisel if it is desired to open the attic and gain free access to these parts. When the diseased parts are curetted or

the ossicles removed the membranous flap is replaced in the canal and held in place with a gauze pack carefully and firmly applied. If the flap is lacerated by the detachment or is diseased, it may be resected and the pack applied to the denuded surface.

A Case of Cerebro-spinal Meningitis of Aural Origin.—Lubet-Barbon, of Paris, reports the case of a young girl, 16 years of age, whom he was called upon to treat for severe earache. A few days previous to this she had suffered a little pain in the left ear, followed by a sight discharge of blood from the canal. This passed and nothing more was thought of it until intense pain returned in both ears, associated with photophobia and a state of great nervous excitement without loss of consciouness. The tympani appeared to contain pus and paracentesis was performed. On one side a drop of pus and on the other a little blood was discharged, nothing more. No relief from the pain and other symptoms resulted from this. On the following day the patient showed some stiffness of the nuchial region, intermittent torticollis, and a paralysis of the external rectus of the left eye. The same evening Kœnig's sign became manifest. The spinal canal was punctured by Dr. Tuffier and a small quantity of cerebro-spinal fluid drawn off and examined microscopically. It was found to contain phagocytes and encapsulated diploccocci. A culture injected into mice produced violent infection. The patient died on the sixth day in coma.—*Archives Internat. de Laryngologie, d'Otologie et de Rhinologie*, May-June, 1900.

Ichthyol in Atrophic Fetid Rhinitis.—It was conceded in a discussion at a meeting of the New York Academy of Medicine last winter that ichthyol was the most useful remedy for the relief of this obstinate affection. Beaman Douglass, in an article on the subject, recommends its application in this manner: After cleansing the nose thoroughly with any desirable antiseptic, a pledget of cotton is saturated with a ten or twenty per cent. solution in water and applied to the atrophic areas in the nose. This is allowed to remain from fifteen to twenty minutes, is then removed and oily sprays used to finish the treatment. Other authors recommend its application in the pure form.

Euquinin in Acute Nasal Catarrh.—The two following formulas containing that preparation are given by *Merck's Archives:*

1. Euquinin ..... gr. xxx.
   Fowler's solution ..... m. x.
   Sol. atropin, 1 per cent ..... m. iv.
   Ext. gentian ..... gr. xx.
   Pulv. acacia ..... q. s.
   M. et ft. pilul. No. xii. Sig.—Take one every three or four hours.

2. Euquinin ..... gr. x.
   Atrop. sulph ..... gr. $\frac{1}{30}$.
   Morph. sulph ..... gr. $\frac{1}{2}$.
   Camphor ..... gr. x.
   M. et ft. tablets No. xx. Sig.—One every half hour for six doses, or until throat feels dry, then every two or three hours.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

For Pink Eye.—Dr. Cheatham writes very clearly on this condition, stating its etiologic factor as a demonstrated bacillus, the presence of which produces a micropurulent conjunctivitis. For treatment he suggests boric acid, gr. x, water, ℥i during the day; at night boric acid, gr. xv in vaselin, ℥ss. After the acute stage has passed, he advises atropin sulphate (gr. i to water ℥ss.) dropped in the eye, morning, noon and night, and the eye is bathed four times a day with—

℞ Acid boric .....
   Sodii borat .....
   Sodii chlorid ..... ää ℥ ss
   Ext hamamelis dest ..... ℥ ii
   Aquae ..... ℥ xiii

In severe cases when pain is great, the following is dropped in the eye four times a day:

℞ Atropin sulphat ..... gr. i
   Acidi boric ..... gr. iv
   Cocain muriat 3% sol ..... ℥ ss

When irritation has somewhat subsided, an ointment is ordered containing yellow oxid of mercury and vaselin, gr. iii to ʒss, to be used in the eye once a day.

Astringents should not be used too soon and care should be taken to prevent contagion through basins, handkerchiefs, towels, etc.

Where tonsils are involved, quinin and salicylate of soda internally are indicated and any concomitant condition, either local or general, should be corrected.—*Louisville Medical Monthly.*

Miscellaneous.

MERCUROL.—Ramon Guiteras, M. D., professor of genito-urinary surgery in the Post-Graduate Medical College of New York, states that he has tried mercurol in his clinic. After describing its chemic nature, he states that the weaker solutions had little effect, the stronger were at first irritating, and concluded that the average strength best borne is ten grains to the ounce, or approximately 2 per cent. He had the histories of 100 cases recorded, in 33 of which an examination for the gonococcus was made, revealing its presence in 30 cases. In the remaining 67 cases a clinic diagnosis was depended upon. In one extremely interesting case no gonococcus could be found in the urethral discharge, although gonococci were present in that of some venereal ulcers on the glans.

In these cases a 2 per cent. solution of mercurol was ordered to be injected three times a day, after micturition; the injection to be held within the urethra for five minutes. The reports show that frequently in two days gonococci could no longer be found.

The author discusses the term "practically cured," and sums up by saying that to draw conclusions of value we should consider only cases that have been under treatment for three or more weeks. On this basis he eliminates all but 65 cases from his report and tabulates these as follows:

Ten were cured in four weeks, or 15 per cent.; fifteen were cured in six, or 23 per cent.; twenty were practically cured, as there was no discharge, though there were some shreds in the urin at the end of from four to eight weeks, 30 per cent.

One of the most valuable observations is that *only two cases suffered from complications*, one having developed gonorrheal rheumatism and the other epididymitis. This in itself would tend to argue in favor of mercurol, for where is there any other solution which does not show a greater percentage of complications? When we consider that many claim that epididymitis occurs in 20 per cent. of all cases, the rate of 1 per cent. reported in this series argues in favor of mercurol as a harmless, yet efficient injection.

Another interesting feature is that in only one of the 100 cases was there any marked posterior urethritis. Therefore it would seem that *mercurol quickly destroys the gonococcus, lessens the severity of the inflammation, and tends to prevent the development of complications.* From a comparative study of the different methods, the author concludes that treatment with mercurol is an advance beyond the older methods.—*London Lancet.*

Society Proceedings.

THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

Specially reported for the JOURNAL.

The Southern Surgical and Gynecological Association held its thirteenth annual session at Atlanta on November 13, 14 and 15. The meeting was most successful and was attended by representative men from nearly every portion of the United States.

The visiting members of the association will long remember the hearty welcome accorded them by the Atlanta profession. Luncheons, dinners, drives, possum suppers, etc., were the order of the day. On Tuesday night a smoker was given at the Kimball and many was the toast drunk and good story told. On Wednesday a ball and supper were given and the visitors were afforded an opportunity of meeting the ladies. The regret was that the entertainment could not last through the week. It was remarked that the doctors stood the ordeal very well and left for their homes full of good wishes for the hospitable people of Atlanta.

Papers were read by the following: Drs. Geo. Ben Johnson, Richmond; Howard A. Kelly, Baltimore; Floyd W. McRae, Atlanta; L. S. McMurtry, Louisville; Geo. H. Nobles, Atlanta; Geo. J. Engelmann, Boston; W. G. McDonald, Albany, N. Y.; J. Wesley Bovée, Washington, D. C.; F. W. Parham, New Orleans; Seneca D. Powell, New York; W. T. Westmoreland, Wm. Perrin Nicolson, Atlanta; Jos. T. Jelks, Hot Springs, Ark.; Fred. A. Glasgow, St. Louis; M. C. McGannon, Nashville; Geo. S. Brown, Birmingham; Jos. A. Goggans, Alexandria City, Ala.; W. D. Haggard, Nashville; Wm. A. Quinn, Henderson, Ky.; Geo. G. Earnest and Dr. Hoke, Atlanta.

Dr. E. D. Martin, of New Orleans, and Dr. Mallet, of New York, exhibited new instruments.

Nothing new was elicited on the subject of spinal anesthesia; the consensus of opinion was that it should be used only in such cases where general anesthesia was contra-indicated. Dr. Powell's paper on the use of carbolic acid in surgery, provoked much discussion, pro and con. Dr. Powell claims to have discovered that alcohol was the antidote. So great is his faith in carbolic acid that he uses a five per cent. solution for sterilizing his hands and instruments in preference to heat. He believes it will cure almost any local surgical trouble and will prevent infection.

The association had the pleasure of witnessing an operation at the college by Dr. Howard Kelly. The object was a negro woman from whom he removed a dermoid cyst fully fifteen pounds in weight.

Dr. Powell, of New York, operated in the beautiful little sanitarium of Dr. Holmes. The patient had a tumor of the brain, necessitating the removal of a greater portion of the parietal bone, which the doctor did with his new cranial saw, a very pretty and ingenious instrument.

One of the several new instruments exhibited was Dr. Mallet's ligature passer. This instrument fills a long-felt want, especially in gynecologic work.

Time and lack of space prevent a more detailed account of the meeting. Every paper read was full of interest.

The council made the following recommendations for officers for the ensuing term:

President, Dr. Manning Simmons, of Charleston; first vice

president, Dr. Geo. H. Nobles, of Atlanta; second vice president, Dr. L. C. Bosher, of Richmond; secretary, Dr. W. D. Haggard, of Nashville; treasurer, Dr. Floyd W. McRae, of Atlanta.

General Council: Drs. Geo J. Engelmann, Boston; Ernest S. Lewis, New Orleans; Geo. Ben Johnson, Richmond; L. McLane Tiffany, Baltimore; Louis S. McMurtry, Louisville.

A resolution was adopted thanking Dr. W. E. B. Davis, the retiring secretary, for the valuable services rendered by him during his long term of office. Dr. Davis has been the secretary of the association ever since its organization. Resolutions were also passed thanking the good people of Atlanta for their generous hospitality. The meeting adjourned to convene in Richmond, Va., November, 1901.

The New Orleans profession was represented by Dr. Edmond Souchon, of Tulane University Medical Department, and Drs. F. W. Parham and E. D. Martin, of the New Orleans Polyclinic.

Louisiana State Medical Society Notes.

The Next Meeting of the Society will be held in New Orleans, April 18, 19 and 20, 1901. Dr. F. W. Parham, New Orleans, President; Dr. H. B. Gessner, New Orleans, Secretary; Dr. Isadore Dyer, New Orleans, Chairman Committee of Arrangements.

The Committee of Arrangements urges all chairmen of sections to prepare their subjects for general discussion; the following has already been announced:

Section on Surgery.—Dr. E. D. Martin, Chairman, 115 Chartres street, New Orleans. Subject for general discussion: Treatment of Fractures of the Long Bones of the Upper and Lower Extremities.

All papers on the above section, whether on the subject announced or other surgical subject, should be sent to the chairman of the section or to the chairman of committee of arrangements.

As other subjects of sections are reported to this department, their titles will be tabulated here.

Medical News Items.

The Louisiana State Board of Health, under the law, is making efforts to obtain correct vital statistics throughout the State, and a circular has been issued giving instructions and also a list of the health officers appointed by the police juries.

Each parish health officer (or coroner) must tabulate the report for his parish. The law requires only quarterly reports, but for purposes of better record the official blanks furnished by the secretary of the State Board of Health are arranged for monthly reports, with the intention of having three of these forwarded by the parish health officer or coroner at the end of each quarter.

The Bertillon classification of causes of death is printed on the back (reverse side) of each report blank, so as to be always at hand for reference by health officers in compiling returns.

This classification has been recommended by the Committee of the American Public Health Association and by the Conference of the State and Provincial Boards of Health of North America. It is scientific, logic and complete, and is recommended to the health officers of Louisiana on its obvious merits. By conforming to it uniformity will be secured.

Parish health officers and coroners are to have the three monthly reports for October, November and December, 1900, in the hands of the secretary of the State Board of Health within the first week of January, 1901.

Health Officers of towns are to send reports to the parish health officers of their respective parishes, and not to the secretary of the State Board of Health.

Parish health officers will include the reports of large towns in the general report for the parish, and will then transmit the town reports to the secretary of the State Board of Health for permanent filing.

This will facilitate the compilation of mortality tables of towns for a separate report if subsequently desired.

Shreveport Charity Hospital Notes.—At a meeting of the board of administrators of this institution, held November 13,

Dr. Oscar A. Dowling was elected consultant on the eye, ear, nose and throat. Both Dr. Dowling and the institution are to be congratulated; the doctor is well and favorably thought of in New Orleans, where he made many friends during his stay here. The present personnel of the staff at the Shreveport Charity Hospital also includes Dr. Randell Hunt, surgeen incharge; Dr. J. M. Calloway, assistant surgeon, and the matron, Mrs. M. S. Lynch.

Tri-State Medical Society of Alabama, Georgia and Tennessee.—The twelfth annual meeting of this popular society was held in Chattanooga Thursday, Friday and Saturday, October 11, 12 and 13.

A special feature of the meeting was the presence of a number of members of the Mississippi Valley Medical Association, who added much to the interest of the meeting by the part they took in the proceedings. A pleasant feature was a "smoker" given by the Chattanooga Medical Society on the second night.

The president's address, by R. R. Kime, of Atlanta, was the special feature of the first night. His subject was "The Relation of the Profession to the Public." He dwelt on the duty of the profession to protect the public against their own folly in the use of dangerous drugs, coal tar derivatives, opium, alcohol, etc., and suggested that a committee be appointed for the study of social problems affecting the development of the race, to secure papers and discussions on social questions, to report on the night of the first day.

The following officers were elected for the ensuing year: President, Dr. M. C. McGannon, Nashville, Tenn.; vice presidents, Drs. W. G. Bogart, Chattanooga, Tenn., Seale Harris, Union Springs, Ala., and Michael Hoke, Atlanta, Ga.; secretary, Dr. Frank Trester Smith, and treasurer, Dr. Geo. R. West, Chattanooga, Tenn. Place of next meeting, Nashville, Tenn.

The meeting will be held in September or October. The time will be decided by the committee of arrangements in the spring.

A Medical Society for the Southwest.—The El Paso County, Texas, Medical Society have invited the members of the regular medical profession of Texas, New Mexico, Arizona and Mexico to meet in El Paso January 17, 1901, to organize a Tri-State or Territorial medical association. Volunteer papers are

requested from all who are willing to contribute, and physicians are especially requested to send in their names and the title of their papers at the earliest possible date, that the program may be completed and sent out in due time. Reduced rates on all railroads.

Drs. S. T. Turner, M. D., W. N. Vilas, M. D., and F. W. Galagher, M. D., are the Committee.

The Mississippi Valley Medical Association have elected the following officers for 1900–1901: President, Dr. A. H. Cordier, Kansas City; Vice Presidents, Drs. C. F. McGahan, Aiken, S. C., and Chas. L. Minor, Asheville, N. C.; Secretary, Dr. Henry E. Tuley, Louisville; Treasurer, Dr. Dudley L. Reynolds, Louisville. The next place of meeting will be at Put-in-Bay, Ohio, September 10, 11 and 12, 1901.

The Medical Department of Tulane opened on November 1, and the class promises to be larger than ever. With a four years curriculum, a better arrangement of work is in force, and the facilities thereby much increased.

The New Orleans Polyclinic began work on November 1. The following are among those matriculated: Dr. F. R. Tucker, Nacogdoches, Texas; Dr. J. A. White, Clarksville, Ark.; Dr. P. A. Tatum, Cherry Ridge, La.; Dr. W. E. Wycough, Salado, Ark.; Dr. C. Nichols, Yoakum, Texas; Dr. R. G. Wilson, Cisco, Texas; Dr. Jno. D. Johnston, Tarentum, Ala.; Dr. J. H. Hicks, Farmersville, Texas; Dr. Clarence Pierson, New Iberia, La.; Dr. R. D. Wilson, New Orleans; Dr. W. C. Rountree, Pecan Gap, Texas; Dr. W. S. Whaley, Athens, Ga; Dr. W. E. Montgomery, Bogue Chitto, Miss.

The American Electro-Therapeutic Association elected the following officers at their meeting in New York City, September 25-27, 1900: Dr. Ernest Wende, president, Buffalo, N. Y.; Dr. Frederic H. Morse, first vice president, Melrose, Mass.; Dr. D. R. Brower, second vice president, Chicago, Ill.; Dr. George E. Bill, secretary, 255 North street, Harrisburg, Pa.; Dr. R. J. Nunn, treasurer, Savannah, Ga. The next (eleventh) annual meeting will be held in Buffalo, N. Y., on Tuesday, Wednesday and Thursday, September 24, 25, 26, 1901.

The New York Skin and Cancer Hospital announces a series of clinic lectures by Dr. L. Duncan Bulkley, on diseases of the skin, to take place Wednesdays, at 4:15 P. M., on and after November 7, 1900. This will be the third series of lectures by Dr. Bulkley, and, like previous courses, they are free to the medical profession.

Married—Dr. F. M. Hoffpauir and Miss Estelle Clark, both of Crowley, La., were married on November 7. The local press describes a very pretty and auspicious ceremony.

Dr. E. H. Walet, secretary of the Orleans Parish Medical Society and a rising member of the New Orleans profession, became a benedict on November 14. Miss Mary Gauche, of New Orleans, was the fair converter.

Mississippi State Examination.—Of thirty applicants before the Mississippi State Board of Health, twelve were admitted to the practice of medicine. The next meeting will be in May, 1901, and two days will be given to the examinations, four branches each day.

The Medical Department of the University of Texas, at Galveston, is announced to open on November 15, and to continue until June 29, with the same faculty and facilities as heretofore.

The Annual Election of Officers of the Orleans Parish Medical Society will take place on Saturday night, December 10.

The New Orleans City Board of Health has been active recently investigating food adulterations, especially preserved meats.

A Note of Comment.—"An Eastern concern, which makes an imitation of Gude's 'Pepto-Mangan,' and for years, has traded upon the reputation which this preparation has earned for itself, has recently sent broadcast to the medical profession of America a circular letter, in which, after bewailing the enormous returns brought by the unethical methods of other manufacturers, modestly refers to its own ethical virtues, and expresses the belief that, in spite of present non-appreciation

of these virtues by the doctors, the day will come when physicians will realize the importance of ceasing to be the *instigators and propagators* of the popularity of certain proprietaries and will patronize *ethical* preparations—like *theirs*, for instance.

"The time has gone by when either doctor or druggist can be deceived by false play. Every member of both professions knows that 'Gude's Pepto-Mangan' is a preparation of genuine value, manufactured on scientific principles, by reliable men, and introduced to physicians in an ethical manner, solely on its merits."—*National Druggist.*

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Treatise on Mental Diseases. By HENRY J. BERKLEY, M. D. D. Appleton & Co., New York, 1900.

The practical character of this work is amply evidenced in the selection of illustrations which though few are of the best. The subject matter is arranged in logic sequence, and each chapter is in itself a comprehensive treatise. Full scope is given in the discussion of the elemental brain and nerve structure before the types of disease are considered. While each chapter deserves especial notice, the more notable are those on the Psychoses of Old Age, the Psychoses of Childhood, the Insanities of the Puerperal Period, Neurasthenia and those dealing with the pathology of mental diseases.

The publishers have spared nothing in the making of the book.

DYER.

Normal Histology. By EDWARD K. DUNHAM, PH. B., M. D. Second Edition. Lea Bros. & Co., New York and Philadelphia, 1900.

From the study of the development of the idea of a cell, the elemental tissues and the relations of these, the text is comprehensive in its detail, and throughout profuse illustration characterizes the work as complete. The scheme of the book makes the study of histology consistently clear

and as a reference or text it is admirable. In successive chapters the study of the various tissues and of special organs of the body is taken up, and finally the work concludes with a chapter on the methods of microscopic technic which is as clear and comprehensive as the preceding descriptive text. DYER.

Essentials of Physical Diagnosis of the Thorax, by ARTHUR M. CORWIN, M. D., instructor of physical diagnosis in Rush Medical College, etc. W. B. Saunders & Co., Philadelphia, 1900.

This is the third edition of a little book containing 213 pages in good print. The work is what the author claims for it, a condensed statement of the essentials of the science of physical diagnosis as applied to the thorax.

As a guide to the further study of the literature of this important subject and as a handbook for students it deserves the place it has earned.

LERCH.

Practical Uranalysis and Urinary Diagnosis. A Manual for the use of Physicians, Surgeons and Students. By CHARLES W. PURDY, LL.D., M. D., etc. F. A. Davis Company, Philadelphia, 1900.

We have the fifth edition of this popular work before us and deem it entirely unnecessary to recommend it, as the reputation of the author and his work are too well established. We will, however, call attention to some new additions that have been made. Improved methods and new tables have been introduced in the chapter on centrifugal analysis. After an experience extending over many years the author comes to the conclusion that by their means the quantities of ulbumin and chlorin, of phosphoric and sulphuric acids, may be determined with an accuracy equal to that of any other method. On page 66 the author makes the interesting statement that it has been repeatedly demonstrated in his laboratory that the use of modern centrifugal methods has made it possible to make in from twenty minutes to half an hour, a fairly complete analysis of urin, qualitative and quantitative, which formerly required 24 hours.

The chapter treating of the microscope furnishes a general idea of the instrument and its special use in urinary work. It is intended for the beginner, who will find it a valuable addition to the work. LERCH.

A Manual of Clinical Diagnosis by Means of the Microscope and Chemical Methods for Students, Hospital Physicians and Practitioners, by CHARLES SIMON, M. D. 3d edition. Lea Brothers & Co., New York and Philadelphia, 1900.

The work is essentially practical. It treats of the examination of the blood, the secretions of the mouth, gastric juice, feces, nasal secretions, sputum, urin, transudates, exudates, cystic contents, semen, vaginal discharges and milk. The methods given for examination are modern, and are described in such a manner that they can be utilized by every practitioner.

The book is illustrated with 136 engravings and 18 colored plates, facilitating greatly the study of the subject.

The work has won for itself a reputation which this new edition will enhance. LERCH.

Progressive Medicine. Edited by H. H. HARE, M. D., assisted by CHARLES H. HOLDER, M. D., Vol. III. September, 1900. Diseases of the Thorax and the Viscera, etc.; Diseases of the Skin; Diseases of the Nervous System; Obstetrics. Lea Bros. & Co., Philadelphia and New York, 1900.

With the same care which has characterized previous volumes of this work the present one is marked. Each subject is reviewed from the standpoint of recent contributions bearing on it and, so far as practicable, this is made exhaustive. So the branches of medicine covered by the announcement on the title page are discussed in every phase which has received attention in current literature. While this work is always useful and welcome, the present number is rich in therapeutic and pathologic suggestions. DYER.

Lessons on the Anatomy, Physiology and Hygiene of Infancy and Childhood for Junior Students. By ALFRED C. COTTON, A. M., M. D. Chicago Medical Book Co., Chicago, 1900.

The first chapters of this work relate the anatomy of the newborn and children, demonstrating by illustration and context the differences between these and adults. Some abnormalities are related and remarked. By far the more interesting and valuable part of the book are the chapters on the physiology and hygiene of the young. The author is consistently attentive to detail, the one thing which will make the text serviceable. A number of glaring typographic errors are evident and should be corrected in a second edition. DYER.

Food for the Sick and how to Prepare It, with a chapter on Food for the Baby. By EDWIN CHARLES FRENDE, M. D. John P. Morton & Co., Louisville, 1900.

In a handy volume of about one hundred and fifty pages the author has very comprehensively presented the indications of diet in special diseases and how foods of all kinds may be prepared for the sick. Especial attention is given to peptonizing food, and in a chapter on Food for the Baby many valuable suggestions are given, particularly with regard to what should be forbidden. Altogether the book commends itself for the sick-room. DYER.

A Manual of Personal Hygiene. Edited by WALTER L. PYLE, A. M., M. D. W. B. Saunders & Co., Philadelphia, 1900.

The broadest scope is taken in the presentation of this admirable volume on personal hygiene. In the chapter on hygiene of the digestive appara-

tus, every detail from the care of the teeth to regulation in clothing is brought into the discussion. In like manner, the skin, the vocal and respiratory apparatus, the ear and eye are considered from the standpoint of care and prophylaxis as a means of preservation. The work closes with an excellent chapter on the hygiene of the brain and nervous system and a few pages on physical exercise. Altogether a readable and interesting volume for the physician, this work would not be misplaced in the hands of intelligent laymen. The illustrations are adequate to the text.

DYER.

PUBLICATIONS RECEIVED.

Transactions of the American Ophthalmological Society, Hartford, 1900.

Saunders' Pocket Medical Formulary, by William M. Powell, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

Essentials of Histology, by Louis Leroy, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

The American Illustrated Medical Dictionary, by W. A. Newman, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

Modern Surgery, General and Operative, by John Chalmers DaCosta, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

Modern Medicine, by Julius L. Salinger, M. D., and Frederick J. Kalteyer, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

A Text-Book of Pathology, by Alfred Stengel, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

A Text-Book of the Practice of Medicine, by James M. Anders, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

Bulletin of the Harvard Medical Alumni Association, Boston, 1900.

A Reference Handbook of the Medical Sciences, edited by Albert H. Buck, M. D.—William Wood & Co., New York, 1900.

Eye, Ear, Nose and Throat, by William Lincoln Ballinger, M. D., and A. G. Wippern, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

A Text-Book of the Diseases of Women, by Henry J. Garrigues, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

A Manual of Syphilis and the Venereal Diseases, by James Nevins Hyde, M. D., and Frank Hugh Montgomery.—W. B. Saunders & Co., Philadelphia, 1900.

Rhinology, Laryngology and Otology, by E. P. Friedrichs, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

An American Text-Book of Physiology, edited by William H. Howell, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

Diet Lists and Sick-Room Dietary, compiled by Jerome B. Thomas, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

Bacteriology and Surgical Technique for Nurses, by Emily M. A. Stoney.—W. B. Saunders & Co., Philadelphia, 1900.

A Text-Book upon the Pathogenic Bacteria, by Joseph McFarland, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

Transactions of the Texas State Medical Association, 1900.

Report Eye, Ear, Nose and Throat Hospital, New Orleans, 1899.

A Practical Treatise on Medical Diagnosis, by John H. Musser, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

Stringtown On the Pike, by John Uri Lloyd.—Dodd, Mead & Co., New York, 1900.

Obstetrics, by David James Evans, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

A Manual of Materia Medica and Pharmacology, by David M. R. Culbreth, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

A Text-Book of Histology, by A. A. Bohm, M. D., and M. von Davidoff, M. D.—W. B. Saunders & Co., Philadelphia and London, 1900.

A Manual of Hygiene and Sanitation, by Seneca Egbert, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

International Clinics, edited by Henry W. Cattell, M. D.—J. B. Lippincott Company, Philadelphia, 1900.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR OCTOBER, 1900.

CAUSE.	White	Colored	Total
Fever, Malarial (unclassified)	10	5	15
" " Intermittent		1	1
" " Remittent	7	1	8
" " Congestive	8	1	9
" " Typho	3		3
" Yellow			
" Typhoid or Enteric	9	4	13
" Puerperal			
Bronchitis	4	3	7
Cancer	8	3	11
Consumption	39	29	68
Diphtheria	4		4
Influenza		1	1
Measles	1		1
Whooping Cough			
Pneumonia	20	10	30
Diarrhea (Enteritis)	12	5	17
Dysentery	6	1	7
Gastro-Enteritis	1	1	2
Hepatitis		1	1
Hepatic Cirrhosis	2	3	5
Peritonitis	1		1
Debility, General	1	3	4
" Senile	5	7	12
" Infantile	2	3	5
Bright's Disease (Nephritis)	25	23	48
Uremia	1		1
Heart, Diseases of	31	24	55
Apoplexy	9	4	13
Congestion of Brain	4	1	5
Meningitis	4	2	6
Tetanus, Idiopathic			
" Traumatic	1	1	2
Trismus Nascentium	11	7	18
Injuries	9	8	17
Suicide	1		1
All Other Causes	83	54	137
TOTAL	322	206	528

Still-born Children—White, 26; colored, 16; total, 42.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 18.40; colored, 27.46; total, 21.12.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.02
Mean temperature	74.
Total precipitation, inches	3.55

Prevailing direction of wind, northeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. JANUARY, 1901. NO. 7.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

HYPOSPADIAS AND EPISPADIAS WITH SPECIAL REFERENCE TO THEIR OPERATIVE TREATMENT.*

BY F. W. PARHAM, M. D., PROFESSOR OF GENERAL CLINICAL AND OPERATIVE SURGERY IN THE NEW ORLEANS POLYCLINIC, NEW ORLEANS, LA.

The term, hypospadias, was introduced into science by Galen, and that of epispadias by Chaussier and Duméril. Although it was known to the ancients, being mentioned even by Aristotle, it remained a pathologic curiosity until the beginning of the 19th century. But little was done in the first half of this century in spite of the work of the great Dieffenbach, and of that Napoleon of surgery, Dupuytren. Nêlaton, it is true, had in 1852 proposed and carried out, though with only moderate success, an ingenious plastic operation for epispadias, which, perfected by Dolbeau, is still in favor with some surgeons, but with this notable exception the plastic surgery of the urethra remained dormant until the publication of Bouisson's Memoir in 1861. Duplay's valuable investigations were first published in 1874 and completed in 1880. Thiersch's admirable work was published in

* Read in abstract before the Southern Surgical and Gynecological Association, Atlanta, November, 1900.

1869. From these works most of the real progress of the past quarter has had its origin. But notwithstanding the brilliant work of these men, the possibility of relieving these distressing conditions has had by no means a wide recognition among even those who make surgery a specialty. A few works on surgery have given the subjects of hypo- and epi-spadias thorough discussion, such as the System of Surgery of Duplay and Reclus, Morrow's System of Genito-Urinary Diseases, and, most thoroughly of all works I have had access to, that of Le Dentu and Delbet (article by Légueu) recently issued. (The last edition of Duplay and Reclus I have not been able to obtain at this writing.) The Genito-Urinary Surgery of White and Martin, as well as The American Text-Book of Genito-Urinary Surgery by Bangs and Hardaway, have also very appreciative articles, which will prove useful not only to the student, but to the practitioner of surgery as well.

But the majority of the older works on surgery, as well as the most recent ones, give but scant consideration to the surgery of these distressing malformations, either discouraging any attempt to remedy them or absolutely declining to countenance their surgical relief at all.

Thus Erichsen (1873): "These conditions (hypospadias) are mostly incurable, though plastic proceedings have occasionally been devised and practiced for their relief."

Holmes' System of Surgery (1882): "In the case of hypospadias surgery does not offer any favorable results. The case is one of arrested development, in which the construction of the parts is irremediable."

Reference Handbook (1887): "Plastic operations can rarely be of service."

Stephen Smith's Operative Surgery (1887): "Treatment of hypospadias is advisable only when it appears to be inconsistent with the power of impregnation, or when the opening is so small as to afford a real obstacle to the passage of the secretions."

Keyes' Genito-Urinary Diseases (1888): "Mature surgical judgment can not promise a cure from operative procedure in epispadias. The adaptation of a proper urinal is the best treatment." "Operations for hypospadias are not over-encouraging, but rapid advances are now being made in this direction."

American Text Book (1899): "The glandular forms of hypospadias are of no physiological importance." Of epispadias:

"An operation similar to that just described (Duplay's) is employed for its cure, but is often more troublesome and less successful than that for hypospadias."

Edmund Owen, The Surgical Diseases of Children (1885): "Experience seems to suggest that this slight malformation (glandular hypospadias) had best be left alone." Again: * * * "In these cases (referring to the forms of peno-scrotal and perineal hypospadias) the aperture may require dilatation, but a plastic operation, with a view of carrying on the urethra to the end of the glans, should not be undertaken."

Dennis' System of Surgery, 1895 (article by White and Furness): "It can not be said that the treatment of hypospadias ever completely meets all functional demands. To make a conduit for the urine is comparatively easy, although it is apt to be a tedious matter, by reason of the liability of the sutures to give way. * * * when only the penile urethra is at fault, the same operation [for epispadias] as for hypospadias may be performed, but the deformity of the penis is usually so great that it makes the operation almost useless." Park's Surgery, Vol. II, expresses no opinion as to the possibility of relief.

White and Martin's Genito-Urinary Surgery (1897) not only countenances but encourages operations for the relief of both conditions.

The American Text-Book of Genito-Urinary Diseases, by Bangs and Hardaway (1898), takes decided stand in favor of the operations for both hypo- and epispadias, but remarks of operations for epispadias: "The results of these operations are not so good as in hypospadias, as the development of the penis has generally suffered far more than in that condition and there is less material for flaps."

International Text-Book of Surgery (1900): "Operations for the cure of balanitic or penile hypospadias are seldom successful. The method devised by Duplay is the best." Of epispadias: "Operations for this condition have been less successful than for hypospadias."

Of French works, those of Duplay and Reclus, and of Le Dentu and Delbet are conspicuous examples of the thoroughness with which French surgeons keep in the van of progress in all forms of plastic surgery. But it would be invidious not to commend here the admirable exposition of the subject to be found in the

article by Tilden Brown in Morrow's System of Genito-Urinary Diseases, issued in 1893.

Tillmanns, in his *Lehrbuch der Speciellen Chirurgie* (1890), says that the prognosis of these conditions has been materially improved by operative procedures, and with this view all the best German surgeons are in accord.

Finally, in controversion of the statement above quoted from *Dennis' Surgery*, that "it can not be said that the treatment of hypospadias ever completely meets all functional demands," I would call your attention to the admirable result obtained by Prof. Duplay in an aggravated case related in a lecture delivered by him to his class at Hotel Dieu in 1896 (*Cliniques Chirurgicales de l'Hotel Dieu, Première Série*, Paris, 1897, p. 224). He said: "We have even yet in the service a patient recently operated upon with success, who had been entered at his birth as belonging to the feminine sex. During his whole childhood he had worn clothing of a girl; it was only at the age of fifteen years that the error was discovered and his civil state established. The penis in his case, however, although being altogether badly developed, had not undergone any notable curvature." Towards the end of the lecture he remarked of the results of treatment of hypospadiac cases: "As I have had occasion to demonstrate to my colleagues of the Société de Chirurgie, and as you may assure yourselves on the young hermaphrodite male on whom I operated some months ago at the Hotel Dieu, those results are perfect, as well from the esthetic as from the functional point of view." He concluded the lecture by saying: "Miction becomes in these conditions absolutely normal. The same is true of the genital functions. Not only is copulation rendered possible, but fecundation likewise, and I could cite you several examples of individuals afflicted with perineo-scrotal hypospadias, for whom coitus was absolutely impossible, but who, thanks to my surgical intervention, married and have become fathers of families."

Such cases I believe make further argument in favor of intervention in cases of this deformity unnecessary. It remains now only to discuss the various operative procedures which form the resources of the surgeon in attacking the different problems in this rich field of plastic surgery. First, it will be best to understand what faults are to be corrected, in other words what are the lacking functions to be restored.

The physiologic requirements may be summed up under three heads:

1. Typical urination, including the two ideas of control of its initiation and the proper direction of the stream;
2. To make coitus possible, and normal;
3. To make fecundation possible.

All will be ready to admit that any operation that can accomplish all these esthetic and functional desiderata deserves to have place among our valuable surgical resources. To admit meekly that "Nature triumphs over art, and here is the boundary between what is Godlike and human," making this our excuse for surgical *laisser aller*, is to negative the idea that the mind can inform the hand and give it such cunning as will enable it to do away with much of the *misery* with which erring nature has afflicted us. Let us now consider the different degrees of deformity and examine them to see in how far they may involve alterations of the normal functions of the genito-urinary apparatus.

We shall take hypospadias first. These may be conveniently divided, agreeably to the classification of Duplay (*Clin. chir. de l'Hotel Dieu*, 1897), into:

1. Balanic, referring to cases where the urethra ends on the glans;
2. Penile, including all cases where the urethra discharges between the glans and the scrotum;
3. Peno-scrotal, including the cases where the urethra opens at the peno-scrotal angle or just in rear of it;
4. Perineo-scrotal, those involving both perineum and scrotum.

In the first or balanic form, of which according to the etiologic classification of Loumeau* there are many varieties, there is ordinarily little interference with physiologic function; hence these cases, it is generally agreed, will not often require surgical intervention. The surgeon should try to persuade the patient of the non-necessity of the operation, but as there are cases in which mental depression demands it, the surgeon will be justified in undertaking it. It will be done otherwise for cosmetic reasons, but not on account of distinct interference with physiologic function.†

* Not less than eleven varieties have been depicted by Loumeau and Kaufmann.

† Beck's operation is so simple and effective that it may be done without hesitation in all balanic cases.

In the second form miction is normal, unless the urethral opening is near the scrotum, when the individual will have to take certain precautions against soiling the clothing; copulation is possible unless the penis shows a pronounced incurvation against the scrotum, (this was proved in one case of Duplay's by the man's having gonorrhea). When the penis is strongly drawn against the scrotum, even coitus will be constrained and impregnation can scarcely ever result unless possibly in cases where the meatus is not far behind the glands. In this class of cases the indication for operation is formal and the more imperative the further the meatus urinarius is away from the glans, or rather, the nearer it is to the scrotum.

In the third degree, the peno-scrotal, the meatus opens at the junction of the penis and scrotum or somewhere behind this point and in front of the perineum, the penis and a portion of the scrotal urethra, being, therefore, involved in the urethral hiatus, being completely or only partially without floor. With rare exceptions this form is nearly always accompanied by a curvature of the penis more or less pronounced even in the flaccid state, and much more accentuated in the state of erection. Here all three functions are at a severe discount. Urination is extremely embarrassing, the individual so afflicted being in aggravated forms compelled to divest himself of his clothing to avoid wetting it and being forced to take the position of a female in urinating. Coitus is, perhaps, not absolutely impossible in the less severe forms but usually can only be accomplished by some subterfuge. A remarkable case is that reported in Gould's Anomalies and Curiosities of Medicine where the patient actually married and by his mechanical ingenuity successfully deceived his wife for a long period. Fecundation is practically impossible. Operation here is absolutely demanded.

In the fourth form the deformity reaches its extreme degree, the scrotum being divided into two halves, looking so like the labia majora as to deceive one without a careful examination. Tillaux in his lectures (*Leçons de Clinique Chirurgicale*, 1895, p. 367), tells how he came very near making a serious error of this kind. The urethra opens at the bottom of this fissure. It might well be denominated false hermaphrodism. The case above described of Duplay's is a remarkable example of such a case, happily, however, restored by this surgeon's skilful hand to useful citizenship.

In this variety coitus is impossible; indeed, the more pronounced the erection the more the organ is bent forward. Fecundation, of course, therefore, is out of the realm of possibility.

Micturition is retromingent and necessitates a squatting position to avoid soiling the clothing. Such a sufferer can, indeed, bless the hand that reconstitutes him a man.

Up to the time when Duplay undertook his researches such cases were considered beyond the resources of chirurgic art, but now all degrees of hypospadias have been brought within the limits of operative surgery. Having discussed the physiologic requirements let us see further in what manner the surgeon must proceed in order to attain them.

The initiation of micturition being fully under control, our surgery will not be concerned with that; we must, however, restore the power of properly directing the stream and our success in accomplishing this will also in most cases be rewarded by a restoration of the functions of coitus and fecundation.

The indications then are:

1. To straighten the penis;

2. To restore the continuity of the urethra up to the normal position of the meatus.

1. For a successful method of doing this we are indebted to the genius of Bouisson (1861). He recommended a transverse incision through the band causing the curvature and then uniting the skin in a longitudinal direction. This will often suffice, but Duplay advised, if necessary, to cut the intercavernous septum, their sheaths or, if need be, the cavernous bodies themselves.

Gross mentions (Urinary Organs, 3rd ed., 1876, p. 559), that Physick many years previously had operated by taking out a wedge-shaped piece of the cavernous bodies and closing the hollow V by sutures. This he says was done also by the elder Pancoast in 1844 and he (Gross) had himself "practised it several times with the most gratifying results." To this operation White and Martin object that the portion of the corpora in front of the repair-line would fail to participate in erection. Even, however, were this invariably true, the mere straightening of the penis would be a great gain in micturition, at least. The difficulty of straightening the penis in some cases is well shown by

dissection of a case made by J. L. Petit (Wood's Handbook, Vol. V., p. 563).*

Before the succeeding steps for restoring the canal are undertaken it is advisable to wait until all signs of inflammatory reaction shall have subsided. Then the restoration of the canal will be much facilitated.

2. The restoration of the urethral canal. This includes the ideas of (1) simply making a continuous channel from the bladder to the end of the glans, and (2) making it in such a way as to restore the function of ejaculation as well as that of urination. In other words, the channel must be so reconstructed of skin and, as far as possible, of erectile tissue as to be a fair substitute for the natural canal.

The desiderata are: epithelial lining for the canal, thick and non-contractile walls in the penile portion and spongy tissue in the glandular. Operations which have been suggested may be grouped under three heads: 1. Simple canalization or tunnelization; 2. Simple approximation; 3. Flaps.

Dieffenbach in 1845 pierced the glans and left the canula in until cicatrization was complete. Chassaignac (*Traité des Opérations Chirurgicales*, vol. i, p. 839) credits Dupuytren with this suggestion, stating that this surgeon had cured two patients by this method, but how long they remained well, he does not say. After examination of all the methods proposed up to his day (1856), he became convinced that they all had one technical vice: they all failed to assure the continuity between the old canal and the new. He carried out an ingenious technic for promptly connecting the two portions of urethra. He introduced a grooved staff into the existing urethra, groove looking downward. A trocar was then pushed through the inferior wall of the urethra (at right angles to the staff) and having met it, and

* He inflated the cavernosa, giving rise to the same curvature as seen during erection in the hypospadiac; the urethra was shortened and incapable of extension. He separated it carefully from the cavernosa, but the cavernous bodies when injected still lengthened themselves but little and the penis remained curved. He separated them from all other parts and drew upon both ends; when blown up they took the original curve. Attributing this to a band still remaining where he had separated the urethra, he removed this, where possible, without opening the cavernosa, and cut it where it could not be removed. Inflated, the organ still took the curved position. He then dried the corpora while still inflated and cut one longitudinally, the other transversely; he found the cells nearest the urethra the smallest and gradually enlarging toward the convex side where they were largest. Whether this vicious conformation was the original or the result of growth could not be determined. Such cases are practically beyond the reach of our art; they are fortunately rare.

the staff being withdrawn, the trocar was pushed on through the glans until it emerged about where the normal meatus should be. A thread was drawn through and left as a guide; sounds of increasing size were from time to time carried through this new channel, thence on into the urethra and so into the bladder. Finally, the abnormal meatus was closed. But Chassaignac mentions no case which he had been able to follow for a sufficient time to say how long the canal remained patulous. Undoubtedly, this procedure must be rejected as unsurgical. Likewise, the use of the red hot iron to make the canal. But if after boring the canal it could be lined with skin the operation could be considered a good one, since, although there would still be a tendency to narrow from contraction of the subjacent tissue, the behavior of grafts placed on fresh wound surfaces gives the hope that the passage could be kept easily patulous by the use of sounds from time to time. In this category would fall the procedure suggested and practiced with success by Van Hook (*Annals of Surgery*, vol. xxiii, 1896, p. 378). In this operation he splits the prepuce and making a tube (mucous surface in, raw surface out) around a piece of gauze, carries it through a tunnel in the gland. This procedure is illustrated in the accompaning cuts (figs. 1, 2 and 3). The method of Nové-Josserand (*Revue de Chirurgie*, No. 4, 1898) is also worthy of

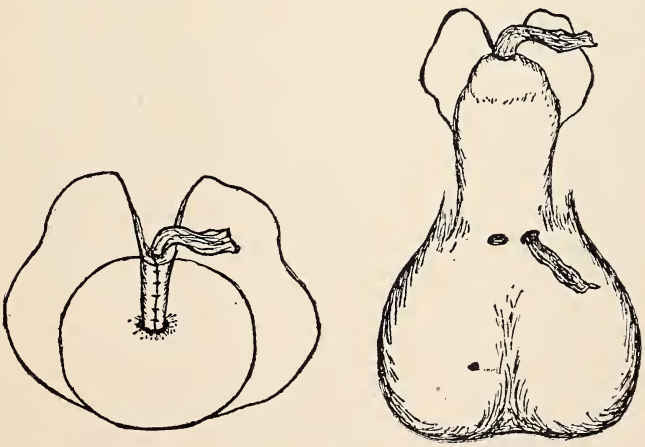


Fig. 1. Weller Van Hook's Operation. Fig. 2.

The two figures indicate the formation of a preputial lining for tunnel through the penis.

(From *Annals of Surgery*).

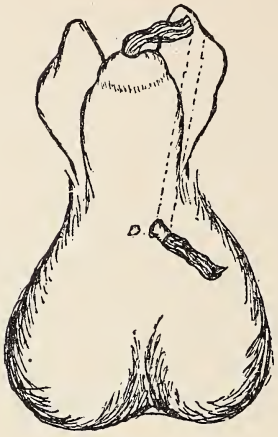


Fig. 3.
Indicates the site of the skin-flap when introduced from below upward.

consideration. (See figs. 4, 5 and 6). He makes just in front of the hypospadiac opening a transverse incision 2 *cm*

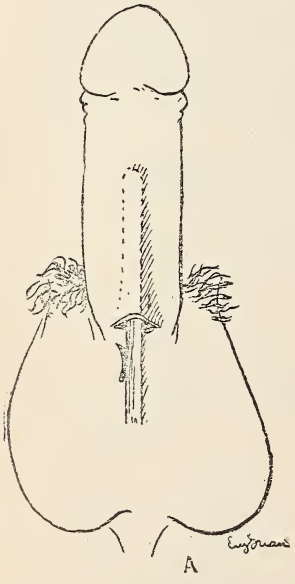


Fig. 4.



Fig. 5.

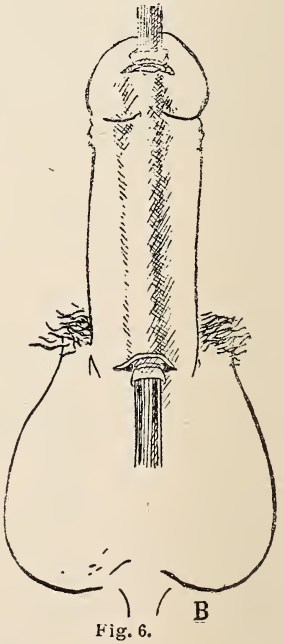


Fig. 6.

Nové-Josserand's Procedure.

long. He then undermines the skin with blunt instruments from this point to the situation of the normal meatus.

Having cut a graft from the thigh 4 *cm.* wide and having wrapped it around a No. 21 or 22 (French) sound, raw surface out, fixed in place by a ligature at each end and two sutures intermediate, he carries the whole through the tunnel already made.* This is left in 8 to 10 days and then a bougie (No. 19 F.) is passed daily for some days. About two months afterward the result could be considered definitely accomplished, the subjacent tissue having ceased to contract. Légueu thinks the fear of ultimate contraction of the canal ought to be definitely discarded. Tuffier and Berger (Hildebrand's Jahresbericht, 1897, p. 849) have both done this operation with success. It is certainly an admirable procedure, and like Van Hook's has the great advantage over those of the type of Duplay's of permitting the whole canal to be made at one sitting.

The originator of this ingenious procedure lays stress upon certain points in the technic, and a failure to carry out these was the explanation of only partial success in his first case. In this case he made the tunnel too small and (as a consequence of this fault) began too soon the passage of sounds. The delicate epidermis was more or less torn off or damaged and the contraction of the canal was more difficult to prevent. Bearing this case in mind he made the canal in his second case large enough to lodge a No. 21 sound and did not begin the passing of the sounds (soft) until the tenth day, and then began with a No. 19 F. so as not to damage the lining as in the other case. The result was prompt and complete, leaving nothing to be desired.

Rochet, of Lyons, has proposed a modification of this operation, which is made sufficiently clear by the accompanying cuts taken from *Centralblatt für Chirurgie*, No. 34, 1900. I have not seen the original article in *Gaz. Heb. de med et de chir*, August, 1899, and do not know the details of the technic, but it seems to differ from that of Nové-Josserand, in that the new urethra consists entirely of scrotal skin, is attached by a pedicle to the scrotum and is held about the sound by a *continuous* suture. This ought to give an excellent result, and with a perineal opening for bladder drainage there ought to be little difficulty in getting with some certainty a definite result at one

*These Thiersch-Ollier Grafts will find, I believe, useful application in the repair of urethral lesions, in appropriate cases, and, indeed, in the surgery of all the orifices, especially the nares where grafts may be wrappedabout an Asch's hollow intranasal spilt.

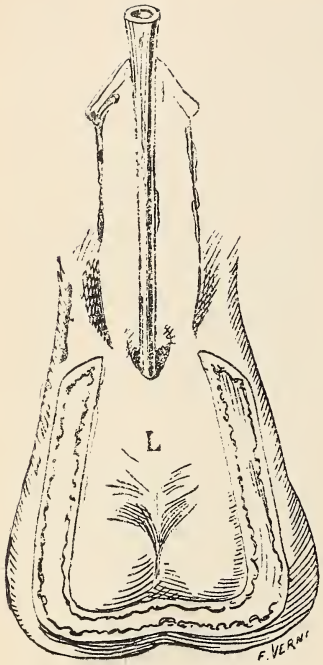


Fig. 7.
Rochet's Operation

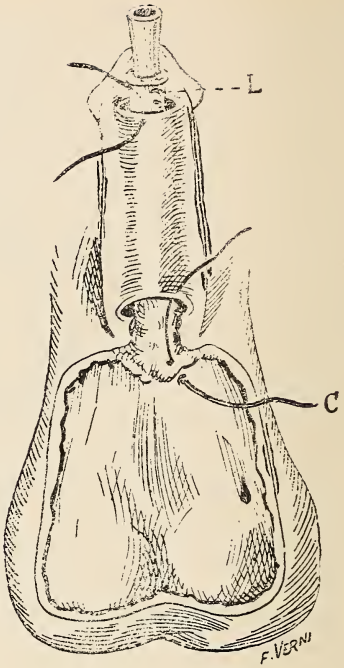


Fig. 8.

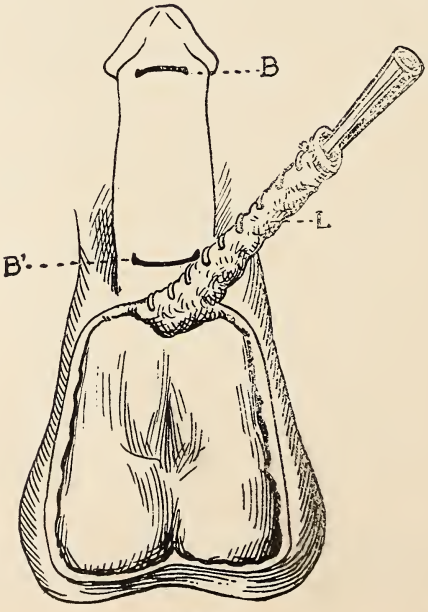


Fig. 9.
The raw surface is to be closed by simple approximation.

operation. A little management of the skin under the sound where it crosses the peno-scrotal junction will insure quick union all along the line of the skin tube without in any way interrupting the vascular connections between the scrotum and transplanted tube.

Beck's operation (*New York Medical Journal*, January 29, 1898), would properly come into this category; it differs from those of Van Hook and Nové-Josserand, in that it lines the new canal with the urethra itself. The operation is founded upon the extensibility of the urethra which Beck has thoroughly demonstrated in the article above mentioned, and particularly in his last article just received.* Valentine has recently (*New York Medical Record*, July 28, 1900), reported a case successfully treated by this method. He gives a very clear description of the operation, which he much extols. A careful



Fig. 10.

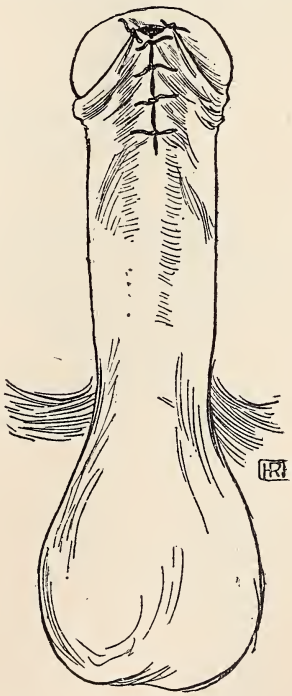


Fig. 11.

Illustrating Beck's Original Procedure.

(From *N. Y. Med. Journal*).

* See *N. Y. Med. Journal*, December 8, 1900.

study of the two descriptions of the operation by Beck and Valentine shows some material differences in technic. Thus, Beck after loosening up the urethra from its bed stitches it to the freshened surfaces of the balanic groove, while Valentine tunnels out a canal under the furrow and pulls the urethra through, thus gaining additional support. For the honor of American surgery Valentine has well substantiated the claim of Beck of priority for this admirable procedure. Légueu mentions the names of Beck, Bardenheuer and von Hacker, as if they had proposed differing technics, but undoubtedly the credit belongs to Beck. The complete ignoring of Beck by some of his German imitators reminds one of the passage in Sir William Ferguson's lecture on hare-lip. Referring to some original views expressed by him, "nor need I," said he, "do more than to advert to the amiable and flattering device of a continental admirer bringing them all out anew, a few years after, as if they were his own."

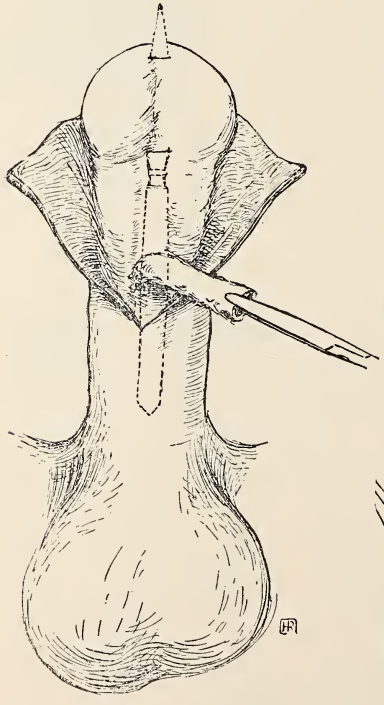


Fig. 12.

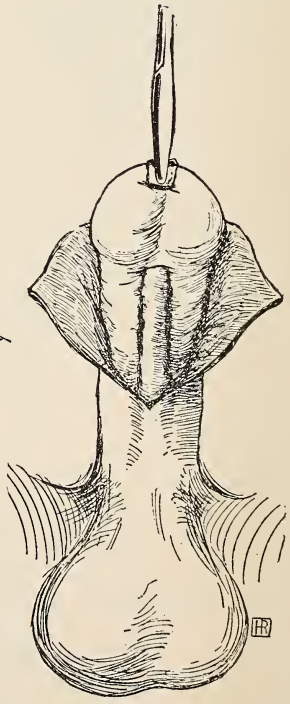


Fig. 13.

Tunneling of Glans by Knife.

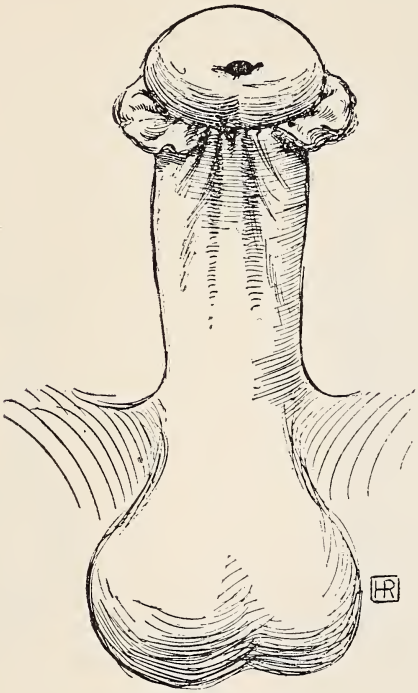


Fig. 14.
Operation Completed.

Bardenheuer has given credit to Beck as the originator of the operation. (See *Centralblatt für Chir.*, No. 44, 1898, p. 1089.) He, however, proposes a modification which is practically the

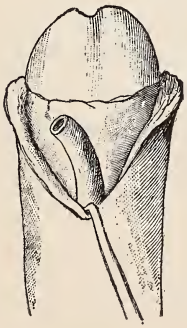


Fig. 15.

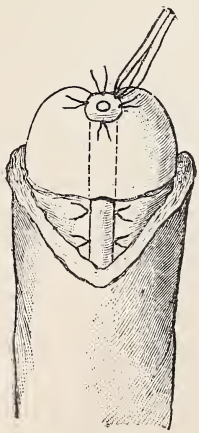


Fig. 17.

Bardenheuer's Modification by Trocar.

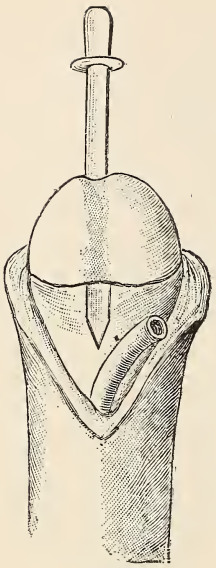


Fig. 16.

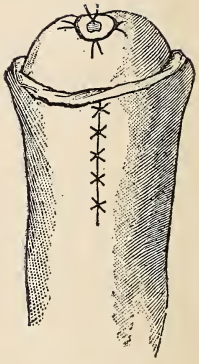


Fig. 18.

Bardenheuer's Modification.

same as that carried out by Valentine and described by him in the article referred to. Bardenheuer uses a trocar to do the tunnelling, whereas Valentine and Beck use a long narrow knife which seems to me the preferable procedure. Beck inferentially concedes to Bardenheuer priority for this modification in his article in *Centralblatt für Chir.*, No. 1, 1899, although he there remarks that he (Beck) has added the modification of tunnelling with knife to his technic in operations subsequent to his first two publications. The cuts taken from Breuer's article illustrate this modification of the original Beck operation.† See figs. 15, 16, 17, 18.

I have done this operation myself recently with great satisfaction. One is surprised at the ease with which the urethra, when freely dissected up, can be drawn out. Depending as it does upon the extensibility of the urethra, the operation is, of

†Von Hacker also claims the origination of this operation and fails to give Beck any credit at all. (See *Beiträge zur kl. Ch.*, Bd. xxii, Hft. 1, Aug., 1898, and *Centr. f. Chir.*, No. 1, 1899, p. 32), although Beck antedates him by months in both operation and publication. From a private letter just received from Dr. Beck as this goes to press, I have reason to believe that Beck's claims were simply ignored by Von Hacker with a full knowledge of Beck's original publication, although as to the modification he seems to antedate both Beck and Bardenheuer. But the modification, while in certain cases an improvement on the original, is not essential, and we should honestly discountenance the course pursued by Von Hacker and credit the operation unreservedly to Beck. Dr. Beck has also a letter from Zuckerkandl (received the day he wrote me) wherein he regrets that on account of insufficient information he called the operation in his book the "Hacker-Beck" and promises to give Beck the entire credit in his lectures.

course, applicable only to cases of balanic hypospadias, or perhaps to cases where the meatus is very near to the corona.

Beck in his last article, just received (*N. Y. Med. Journal*, December 8, 1900), has extended the operation to include even some degrees of penile hypospadias. This is clearly shown in the accompanying figures copied from his article. It will be observed that this procedure is very similar to that of Rochet

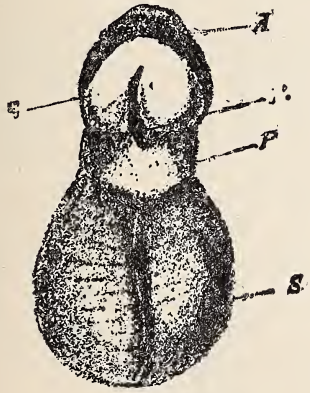


Fig. 19.



Fig. 20.

Kronacker's Operation. (From *Deutsch. Ztschft. f. Chir.*)

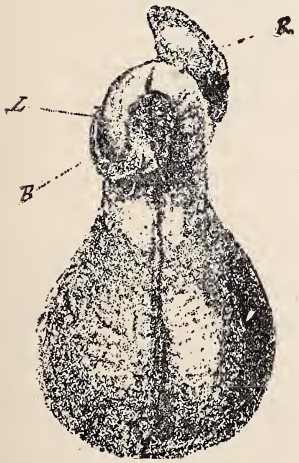


Fig. 21.

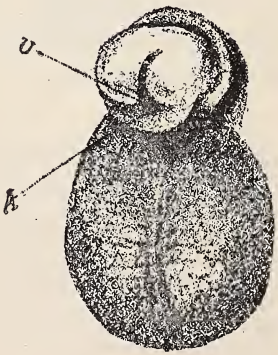


Fig. 22.

above described, though the material is utilized in a different manner. See figures 38 and 39 at the end of this article.

The procedure of Kronacker may also be mentioned here. He utilizes the prepuce to make the glandular urethra (the cuts

will sufficiently explain this.) This would be objectionable by reason of the absence of erectile tissue in its construction and also owing to the thinness of the covering.

We come now to the second group of operations:

II. *Simple Approximation.*—This was first done by Dieffenbach. Here also fall those of Krönlein and Duplay. The operations of Duplay are now classic and well known, and need no detailed description here.‡

III. *The Flap Operations.*—The first flap operation (done for epispadias) was that by Nélaton in 1852, and this operation, variously modified by John Wood, Dolbeau and others, is still recommended even in some of the later works on operative surgery. While not applicable to hypospadias it no doubt suggested those of the type of the Link-Bidder-Landerer-Rosenberger operation. Rosenberger first described this operation at the Twentieth German Surgical Congress in 1891. This consisted in paring the edges of the penile furrow, extending these pared surfaces to the abdomen, where two parallel strips are removed corresponding to those on the penis. The penis is then carried up to the abdomen, and the two surfaces are united by suture.

Later the penis is cut loose with a flap made by extending the lines parallel up on the abdomen of the length of the new urethra. This flap is severed and folded on to the raw surface of the penile flap. This principle, originally carried out for epispadias, was made the basis of an operation by Landerer and Bidder, apparently independently, for hypospadias. In the case of hypospadias, however, the flaps are taken from the

---

‡ Duplay's first plan was to dissect up two quadrilateral flaps, turn them in over a sound of suitable size, unite them in the median line and cover the raw surfaces by drawing in the skin from the sides of the penis after loosening them up by dissection. He soon found that this plan involved too much traction and the sutures often cut through. The plan he finally adopted, and that which is now the one usually carried out is simply to make parallel incisions one on each side of the penile groove, some millimeters apart; the internal lips of these incisions were dissected up the least bit so as to turn them toward, but not completely over the sound, the external lips, on the contrary, were freely dissected up so as to pull the skin over the sound and cover it well in. The drawing in of the two external flaps drew in the two internal flaps and caused them nearly, but not quite to touch in the middle line. The small space left between the edges of the internal flaps must, of course, heal by granulation and formation of cicatricial tissue, but Duplay says it is so little that it is almost linear and does not militate against the maintenance of an almost normal canal.

Routier has suggested (See Nové-Josserand's article in *Revue de Chir.*, April, 1898.) a plan which is really a recurrence to that discarded plan of Duplay's.

Before leaving this section I should remark that the results of a successful Duplay operation for hypospadias are excellent, for as Légueu remarks, the urin is passed with force and in ample volume, the erection is rectilinear and permits normal coïtus, and the spermatic fluid being ejected with force in the proper direction impregnation becomes again a possibility. If, however, after various unsuccessful attempts this operation fails, then resort must be had to one of the flap operations.

scrotum, albeit in practically the same way as in Rosenberger's procedure.

The procedure of Link is somewhat different in its technic, although practically the same in result. He cuts away a narrow strip from each side of the hypospadiac furrow, and turns up a sufficiently long rectangular flap from the scrotum and unites it to these freshened surfaces, skin surface inward. The outer raw surface of the flap is covered by flaps of skin taken from the sides of the penis and united in the middle line.

John Wood operated by turning in two flaps from the sides of the urethral groove, stitching them there to form the urethra, and then covering the raw external surfaces with the split prepuce.



Fig. 23.

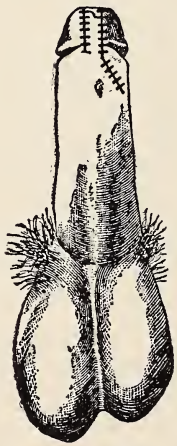


Fig. 24.

Von Frisch's Operation.
(From Universal Annual).

A. von Frisch (*Universal Annual*, 1893, E. 7), has suggested a very clever operation. "Between the outer opposing edges of the glans penis he moves up and secures by suture a quadrilateral piece of prepuce which he has dissected up." The figures represent this fully. Kronacker's and Van Hook's use of the prepuce have already been described. In Thiersch's operation for epispadias the prepuce is skilfully employed to establish the continuity between the penile and balanic portions of the urethra.

Regarding the various uses of the prepuce in this surgery, Treves remarks: "It may be pointed out that the integument

of the prepuce and scrotum is not well adapted to form the tissue of a primary flap. It is not readily handled, and the lax subcutaneous layer renders edema a troublesome complication. The prepuce may serve a useful purpose in assisting to close a small defect, and in supplementing a more extensive operation, but it has not yielded satisfactory results when used to form the principal flap." These objections may apply with some force to the procedures of Kronacker, Nélaton, Rosenberger, Bidder, Landerer and Link, but not to that of Van Hook, nor to its use by Wood, whose operation was the special object of the criticism of Treves.

Laurent, of Brussels, corrected a case of deformity in a boy of 9½ years in the following manner (*Universal Annual*, 1896, E. 2):

Two oblique parallel cuts ten centimetres apart were made on the inner side of right thigh, extending upward and outward involving the abdominal region. This skin thus marked out was dissected up, being left attached at the two ends. The lateral borders of the urethral groove were then dissected free and a canal formed by uniting them in the middle line. The penis was now slipped under the thigh flap in such a way as to bring the two raw surfaces together. When union had taken place the penis was cut loose with as much of the thigh flap as was required and the new skin thus gained used in further strengthening the urethral wall. In the Nélaton operation for epispadias, after the flap had been brought down from the abdomen with its epithelial surface in, the raw surface was covered in a manner similar to that of the last procedure by running the penis under a skin bridge dissected up from the scrotum. This operation is well depicted in White and Martin's Genito-Urinary Surgery and in Treves' Manual of Operative Surgery.

The admirable operation of Thiersch, though originally intended for epispadias, may advantageously be employed for the treatment of hypospadias with some slight modifications. Indeed one of the first successful operations for hypospadias, done by Theophile Anger on a young man of sixteen in Paris in 1874, was according to Duplay absolutely identical with the procedure of Thiersch published in 1869. The cuts show this operation of Anger.

Before closing this section of the plastic surgery of the urethra I will refer to the operations for establishing continuity

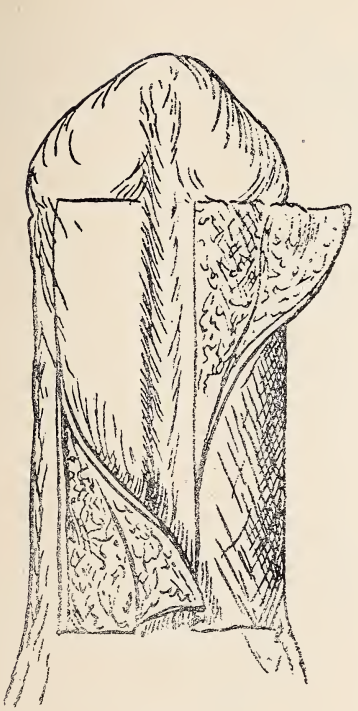


Fig. 25.

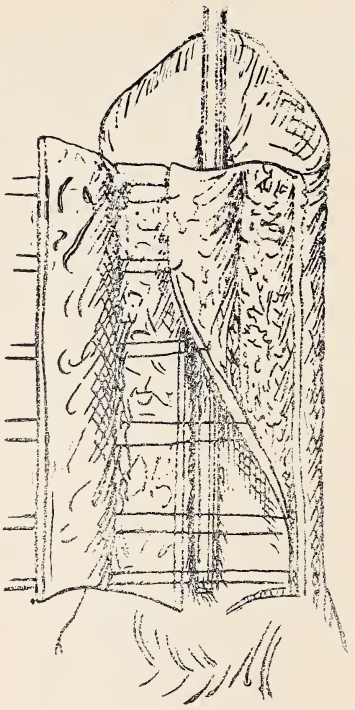


Fig. 26.

Anger's Operation for Hypospadias.
This is practically identical with Thiersch's operation for Epispadias.
(From Stephen Smith's Operative Surgery).

between the various parts of the restored urethral canal, and in the closure of fistula, whether from congenital or acquired causes.

When the opening is small or if larger and the long dimension in the axis of the urethra, the plan of simple approximation with oblique denudation of Verneuil and Vollemier, without inclusion of the mucous membrane, may be successful, or the sliding flap method of Gouley may be tried. (See fig. 27). The method of Loumeau, described by him at the Ninth French Surgical Congress (see Transactions, 1895, p. 577) is a combination of urethrorrhaphy and urethroplasty, modeled after the suggestions of Delpech and Alliot. It consists in freshening a quadrilateral surface about the fistula as a center and then prolonging backward incisions in the lines of the lateral borders of this raw surface. The fistula is then closed by simple

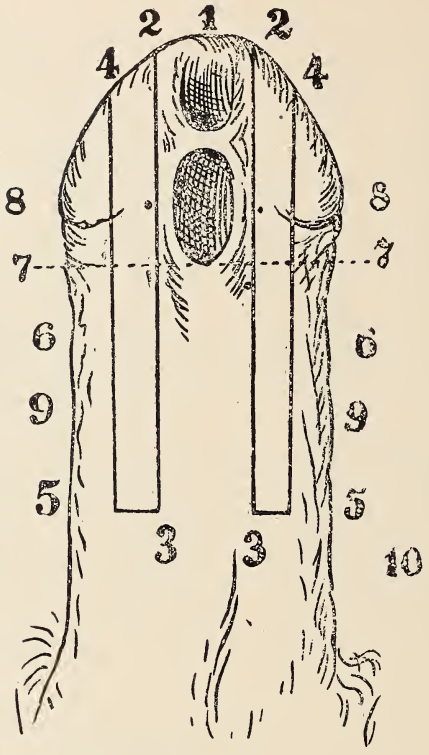


Fig. 27.
Gouley's Operation.
(From Stephen Smith's Operative Surgery).

The central skin is pushed up until 3, 3 comes to 2, 2, and the denuded surfaces are brought into contact, the fold being at 7, 7.

approximation, and the quadrilateral flap, attached behind, is pulled up until it exactly covers the raw surface, where it is held in place by three lines of suture, a transverse and two longitudinal. Loumeau's case made a rapid and uninterrupted recovery. The figures (28, 29, 30 and 31) give a good idea of the procedure. In many cases simple sliding of the edges towards each other, after making incisions on each side or in front and behind and some distance away from the fistulous opening, will answer admirably. Flaps may be taken from the scrotum, from the abdomen, from the thigh or from the inguinal region and applied according to the Indian method, with the raw surface down; but in general the procedures of the French method (skin surface turned in) will give better results. The

doubling methods, or methods by double flap from penis and scrotum, as done by Artaud, Rigaud and Sédillot, may sometimes be required, and will occasionally give good results. The now classic procedures of Thiersch for

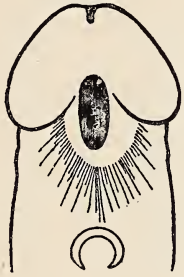


Fig 28

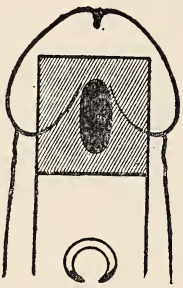


Fig. 29.

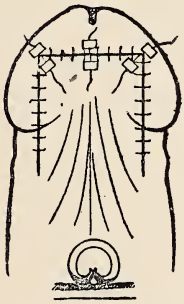


Fig. 31.

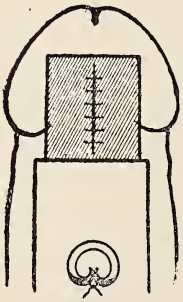


Fig. 30.

Loumeau's Operation.
(From Transactions, 1895).

closing the epispadiac opening between the old and the new-formed urethra is admirable, and answers well, though not applicable, without modification, to hypospadias. In this case the flaps had best be taken from the scrotum, or as recommended by Thiersch for the formation of the penile urethra, or better still as practiced by Szymanowski, a method identical in principle with that of Thiersch. Figures (32, 33 and 34) illustrate this admirable operation, which, like Thiersch's procedure, is applicable to the closure of defects in the penile urethra, whether on the hypospadiac or on the epispadiac side of the penis. Weller van Hook, in one of the cases reported by him, employed in the final closure of the hiatus between the new-made and the old portions of the urethra a flap taken from the scrotum covered by another

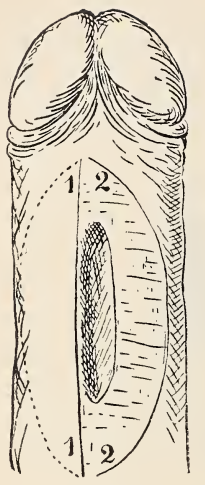


Fig. 32.
Dissection of two flaps.

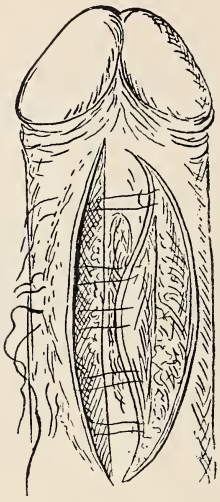


Fig. 33.
Inversion of one flap.
Szymanowski's Operation.

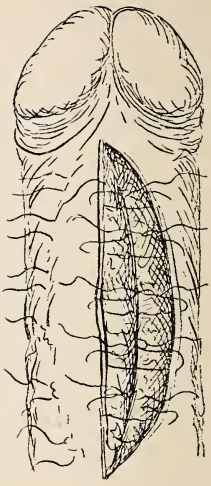


Fig. 34.
Covering of first flap
by the second.

(From Stephen Smith's Operative Surgery).

furnished with a layer of the prepuce. Finally, I may remark that in this work on the penis, where after one stage of plastic work a raw surface is left exposed, this may be at once covered and the operation completed with excellent ultimate results by Thiersch-Ollier grafts taken from arm or thigh. But in most cases, perhaps, as remarked by Duplay, defects of considerable extent may be closed by simple approximation of broadly freshened surfaces, especially if at the same time a perineal urethrotomy is done.

It was the great merit of Duplay and of Thiersch to have shown the tremendous advantage in this delicate plastic work of not attempting too much, but rather of doing it in stages with sufficient intervals to insure the stability of each step, and it was Thiersch who, following the practice first recommended by Louis, Viguerie, Dieffenbach and Ségalas in the treatment of urinary fistula, first demonstrated the advisability of making a perineal opening for turning off the stream of urine from the field of operation in plastic work for both hypo-and epi-spadias. One gets an idea of how great must have been the annoyance of the older surgeons from this cause by recalling the suggestion of Malgaigne to insert a canula suprapubically into the bladder and leave it in until healing could be accomplished.

On this point of perineal drainage of the bladder, Duplay took issue with Thiersch, insisting that a tube passed through the hypospadiac opening during the first stages of the operation, and subsequently through the whole canal from the meatus to the bladder as a catheter *à demeure*, was quite sufficient and satisfactory; but in spite of the conspicuous success of Duplay in this field of surgery, most surgeons nowadays will follow the suggestion of Thiersch and get rid of the annoyance of urin continually slipping alongside the catheter instead of through it. But it would seem that with the urin turned aside more of the work of plastic reformation ought to be done at one sitting and the total duration of the process of cure be materially abridged, though I venture to say that few surgeons will go so far as Tillaux in attempting to complete the operation at one sitting (*Leçons de Cliniques Chirurgicales*, Paris, p. 368). Indeed, in the case which he reports, the urethra gave way behind and required at least one more operation. He would, perhaps, have gotten a better result had he, instead of depending upon the catheter introduced from meatus to bladder, have carried out the perineal drainage of Thiersch.

The Treatment of Epispadias.—Baron (Dolbeau, *de l'epispadias*, Paris, 1861), says that one case of epispadias to 150 of hypospadias is about the relative frequency, but Marchal (Keyes) did not find one case in 60,000 conscripts, whilst Rennes, 1831, says a military surgeon found 10 cases of hypospadias among 3000 conscripts. It is certainly very rare (even if we include the slighter balanic forms), but Czerny in his clinic in Heidelberg treated six cases from 1878 to 1892 (*Annals of Surgery*, Vol. xix, 1894, p. 111). During the same period 14 cases of hypospadias were treated. Although this is an unusually rich clinic, drawing as it does, owing to the reputation of Czerny, from a very extended and populous area in Germany, still the disease is sufficiently frequent and so distressing when it does occur that it merits the most conscientious study of the surgeon.

In addition to the functional errors found in hypospadias we have another in epispadias which is the most difficult of all to correct. I refer to incontinence of urine which occurs in the greater number of cases of epispadias in some degree, whilst in hypospadias it is comparatively infrequent. The failure to

restore the *besoin d'uriner* has rendered most of the operations suggested up to a very recent period unsatisfactory.

The operative procedures which have most engaged the attention of surgeons are those devised by Nélaton (1852), Rosenberger (1891), Thiersch (1869), and Duplay (1874 and 1880). The first, modified by Dolbeau, John Wood and others, is still in some form practiced by surgeons in certain cases, and standard works like Treves' Manual, Waring's Operative Surgery, and White and Martin's Genito-Urinary Surgery, still recommend it, but there can be but little doubt that both this and Rosenberger's are inferior in results to those of both Thiersch and Duplay, however ingenious they may be in technic. Thus, Walter Denison (*Annals of Surg.*, Vol. xxv, 1897, p. 379), after an investigation of all the cases he could find of Rosenberger's operation, concluded that they gave no better results than previous procedures. Though the formation of the canal is quickly accomplished, the incontinence is not relieved, and some better plan must be sought. The procedures of Thiersch and of Duplay are often followed by great improvement of the incontinence, but they, too, leave much to be desired. Perhaps, the procedure of Boiffin (Ninth French Congress of Surgery, Paris, 1895, p. 576) conjoined with that of Thiersch or of Duplay might in some cases be of material assistance in overcoming the incontinence. He did a symphyseotomy after the manner suggested by Farabœuf and, then, having exposed the vesical urethra, wrinkled it up with sutures in such a way as to throw a fold into the urethra. This was found in one case to restore the power of control. Where the pubic bones have failed to unite, the suggestion of Trendelenburg, to draw the bones together by suture, might be worthy of trial. Could this restoration of incontinence be in this or in any other way brought about the operation of Thiersch or that of Duplay would accomplish all the desiderata in the most satisfactory manner. The operation of Thiersch, by double superimposed flaps, is the procedure preferred by most surgeons, but Légueu thinks Duplay's should be selected as the operation of choice, Thiersch's being reserved for special cases. Duplay's takes advantage of the depth of the furrow between the cavernous bodies and aims to utilize as much as possible the mucous membrane lining its bottom and sides, whilst Thiersch simply draws the two skin flaps over the furrow

to form the canal; but there seems no reason why in the Thiersch procedure the flaps may not be so manipulated as to accomplish the same thing as is claimed for that of Duplay. There is a suspicious odor of patriotism in the expressed preference. These operations are so well known and accessible that it would be a work of supererogation to depict or describe them here.

However admirable the results of these procedures may be, and they are, as seen in quite a number of successful cases, still the length of time required to obtain a final cure has been so great as to deter many of us from embarking upon this sea of operative difficulties. Thiersch worked one year and a half to cure one of his cases and remarks that not less than three months should be consumed in the treatment of most cases. Pozzi got an excellent result by this method in three séances. But such cases as his are rare; most of us would grow weary of waiting for the result, to say nothing of the patient. Any method which will give even as good results, but in much shorter time, would be welcomed by the surgeon. Such an operation I believe is that suggested by Cantwell, of Trenton, New Jersey, in 1895 (See *Annals of Surgery*, Vol. xxii, 1895, p. 689).

Whether the cause of the condition be a fetal traumatism of the urethra by dammed up urine, whereby the urethra is unroofed and displaced to the dorsum of the penis, as when a grain of corn pops on the stove be correct or not (and it would seem from recent researches not to be), still the theory was a good working one, for it led Cantwell to propose a very ingenious and effective technic, whereby a definite cure can be accomplished at one operation and in a very short time. His operation reverses the conditions, by separating the cavernous bodies and carrying the urethra between them to its normal situation beneath the organ. This is easily done, for, whilst in the normal urethra the cavernous bodies are so intimately blended that they seem actually to decussate, in the epispadiac they are so loosely united that they may be separated at times by blunt dissection. (Englisch reports a complete separation of the corpora cavernosa.) The technic is well illustrated in the accompanying diagrams. Perineal drainage is first provided for by a urethrotomy and the insertion of a tube, preferably Watson's, which is shown in Tilden Brown's article in Morrow's System, Vol. i, p. 615.

Duplay almost stumbled on the operation as appears in the following quotation: "The cavernous bodies are separated from each other, and only held together by a fibrous partition, often quite thin. By depressing this membrane above and below, the cavernous bodies can be seen obliquing towards each other, leaving a cleft capable of lodging a sound." He did not, however, go far enough, and to Cantwell belongs the honor of the establishment of the procedure on a firm surgical basis. See Fig. 35.

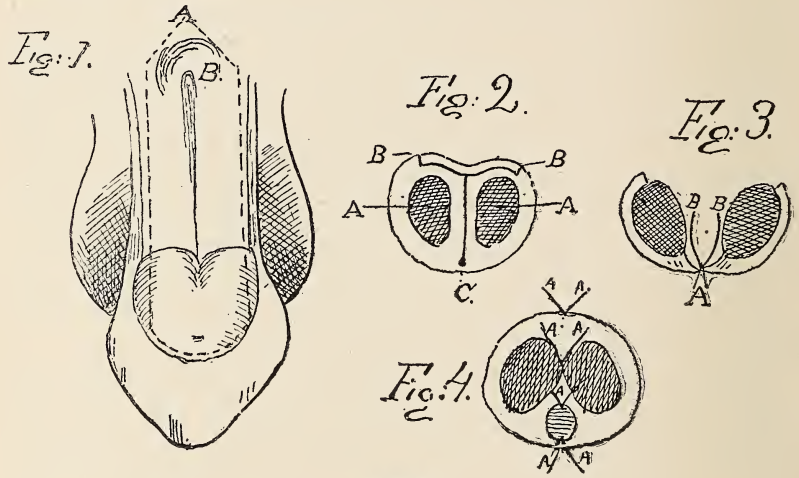


Fig. 35.
Cantwell's operation of sub-penile implantation of the Epispadiac Urethra.
(From Annals of Surgery.)

Herbert Page reports a successful case in a boy of ten years operated on in 1898 by Cantwell's method. The case was a distressing one with dribbling incontinence; when discharged seven weeks after the operation he was able to retain his urin all night and was able to be at school.

He preceded the operation proper by a perineal urethrotomy and the use of a Watson's tube. Asepsis was maintained by keeping the boy during the whole healing process night and day in a boric acid bath.

"It may be said," Page remarks, "that the result of the operation far exceeded our expectations, and while but small experience can be gained from one case only I feel nevertheless that the record of it may be of use in calling the attention of surgeons to an operation of unquestionable value for the treat-

ment and cure of a malformation so grievous and distressing as that of complete epispadias."

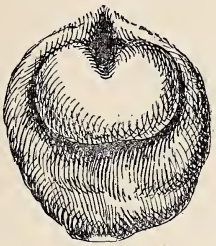


Fig. 36.
Before Operation.
Dr. Martin's Case.

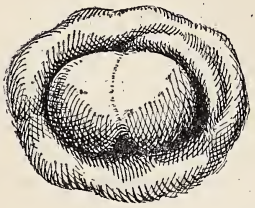


Fig. 37.
After Cantwell's Operation.
The urethra has not been brought entirely to end of glass.

(From pen sketch by Dr. Q. Kohnke).

Through the kindness of my friend, Dr. E. D. Martin, I had recently the privilege of assisting him in the performance of this operation (done at my suggestion) upon a boy of five years of age afflicted with complete epispadias, the abnormal meatus being, as in Page's case, just under the pubic arch or slightly above it. Incontinence of urin was marked. The operation was done in October of this year. A pair of McArthur artery forceps was first introduced through the epispadiac meatus and made to bulge out the perineum. The point being cut out, a soft rubber catheter was pushed into the bladder and retained by a suture. The operation proper was then begun by cutting out the urethral trough bodily by going well beneath it and lifting it freely from its place between the cavernous bodies. The dissection was carried well back to the infundibulum, the anterior wall of which was then caught with forceps and dissected up toward the pubic arch until the whole urethra, almost into the bladder, was well mobilized and could be freely pulled out until it could be extended, as in Beck's operation for hypospadias, nearly up to the normal situation of the meatus. It then looked very much like an open alligator's mouth. It was converted into a complete tube by suturing the sides of this to each other. This being done, the corpora cavernosa were separated by blunt dissection assisted by occasional snips with the scalpel. The glans was partly split so as to provide a place for lodging the new meatus. The new made urethra was then carried through to the under side of the

penis, and the meatus being sutured in place, the cavernous bodies were drawn in front of it and held together by a few sutures passed through them. The operation was completed by bringing the skin over the corpora in the median line. A very shapely organ was the result. The result after healing, which was somewhat delayed and marred by suppuration of the skin flap, while not all that could be desired, was most gratifying. The urethra retracted a little back from its position in the glans, leaving it practically as a post-balanic hypospadias, which I believe may be ultimately corrected by Beck's procedure of urethral extension. In another case, I would pierce the glans with a trocar or narrow-bladed scalpel and pull the mobilized urethra through to its proper position in the glans, and to prevent the disturbing effects of sepsis I would keep the boy in the boric bath as suggested by Page. When the boy was last seen healing was completed and the incontinence was so much im-

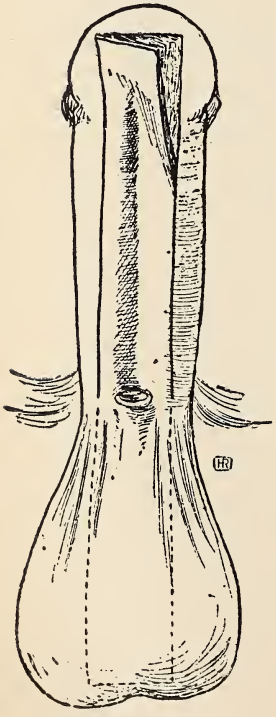


Fig. 38.



Fig. 39.

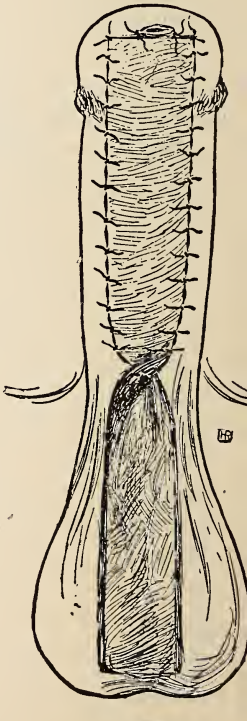


Fig. 40.

Beck's Last Procedure.

proved that he could go regularly two hours or more without wetting his clothes, and we feel confident that as he gets older and he brings to his assistance the natural feeling of pride, the control will be almost normal. Indeed, with our experience in this one case, both Dr. Martin and myself can say without reservation that this operation of Cantwell's is by far the best yet devised for the treatment of epispadias. The possibilities of a combination of the suggestions of Cantwell, Weller Van Hook, Beck and Nové-Josserand in the management of the many variations of this interesting malformation will broaden the operative field of both epi- and hypospadias, and surgery will have cause to be grateful to the genius of American surgeons for giving us these notable additions to its resources.

Addendum: In a letter just received from Dr. Cantwell, he reports that one of his patients, "was married last May and seems contented. He (Dr. C.) is anxiously awaiting a result of the union," "for that will be the crucial test of the operation."

The Doctor remarks: "It has often occurred to me that by following this method, a good operation for bladder exstrophy could be devised, by carrying catheters through a perineal fistula up into the ureters, then dissecting off the bladder wall bringing it over a small rubber balloon, pushing the whole into position and uniting the abdominal wall in front of it."

Clinical Reports.

SPINAL ANESTHESIA IN RECTAL CASES.

By CHAS. CHASSAIGNAC, M. D., Professor of Genito-urinary and Rectal Diseases and President New Orleans Polyclinic, etc., New Orleans.

Numerous cases of spinal or medullary cocainization have already been reported from different parts of the world, but, inasmuch as this method is specially advantageous in operations on the rectum, it will not be considered amiss to report very briefly a series of three cases utilized by me for demonstration in the beginning of the Polyclinic session:

Case I. An ideal one for this method. Interference surgically was imperative, general anesthesia out of the question owing to bad general condition of patient, a middle-aged male.

The case was one of very tight urethral stricture of long standing, accompanied by some cystitis, contraction and hypertrophy of the bladder; as a complication, numerous large vascular hemorrhoids protruding at slightest effort and bleeding profusely daily. Stricture and bladder conditions had been improved by irrigations and use of bougies, but patient was getting feebler from constant loss of blood. I operated with my two assistants, Drs. Delaup and Gelpi, the former of whom made the spinal injection for me; Mr. Samuel, the interne of the ward, and Mr. Crow, externe.

Twelve minims of a 2 per cent. sterilized cocain solution were injected between the third and fourth lumbar vertebræ. Analgesia was evident in four or five minutes and complete in nine. Operation, consisting in dilatation of sphincter, of ligation and excision of three sets of piles, lasted about ten minutes and was entirely painless. Complete lack of sensation of pain lasted for over twenty minutes and partial for thirty-five.

Some headache that night, but no other disagreeable features, and patient made an uneventful recovery as far as the piles are concerned; still under treatment for his urinary trouble.

Case II. A young, healthy negro, with a simple case of complete fistula in ano. Only 8 minims of a 2 per cent. solution of cocain were injected. Analgesia was complete in eight minutes and shortly after extended to the upper extremities.

The operation of finding the inner opening, laying open the fistulous tract and curetting the same was done in a few moments and with the patient in the greatest good humor. Return of normal sensation was slow and gradual and was not entirely accomplished for over an hour. No disagreeable symptoms whatsoever.

Case III. Another in which this method was specially indicated. A middle-aged colored male, presenting himself for the relief of a bad fistula in ano, together with several external hemorrhoids. In addition, physical examination revealed the existence of tuberculosis, chronic endocarditis, and nephritis; the local condition demanded relief, the constitutional precluded he possibility of risking general anesthesia.

Eight minims of the two per cent. solution were injected and analgesia appeared to be complete in about ten minutes. The fistula was incised and curetted, the hemorrhoids were excised and cauterized with the Paquelin cautery. From time to time, the patient complained of some pain, but it was not enough to interfere with the progress of the operation, and may have been imaginary, for he was not sensitive to the prick of a needle on the legs or hips for some minutes after the termination of the operation. There were no disagreeable after effects.

REMARKS: The only case in which headache followed was the first; this was also the only one in which some drops of spinal fluid were lost, thus lending color to the theory that this loss may account for the cephalalgia.

The analgesia was undoubtedly complete and most lasting in the second case, although no spinal fluid escaped through the needle, proving that this is not a *sine qua non*.

The most pronounced result was obtained in the youngest and healthiest subject; the least in the one with advanced organic disease, at the same time the oldest.

Rectal operations require such profound anesthesia that they are very favorable for this method, the moment there is the least fear of general anesthesia.

Opiates may be given safely early enough by the mouth to obtain an effect before the cocain analgesia has ceased, so that the patient is saved not only operative but post-operative pain.

All injections were made only after very thorough preparation of the skin of the back, as I believe the chief danger is from sepsis when the method comes into general use and is resorted to by the careless.

I. A CASE OF LARYNGEAL DIPHTHERIA—TRACHEOTOMY—ANTITOXIN INJECTIONS—RECOVERY. II. THE IMPORTANCE OF AN EARLY DIAGNOSIS OF HEREDITARY SYPHILIS: A CASE IN POINT.*

BY JOHN F. OECHSNER, M. D., ASSISTANT TO THE CHAIR ON GENERAL CLINICAL AND OPERATIVE SURGERY IN THE NEW ORLEANS POLYCLINIC, NEW ORLEANS.

1. It is not my intention to enter upon a dissertation on the subject of diphtheria, its diagnosis, treatment, etc.; but cases of grave laryngeal diphtheria, requiring tracheotomy and event-

*Read before the Louisiana State Medical Society, New Orleans, April, 1900.

ually ending in recovery, are sufficiently frequent, interesting and instructive to justify their recording when we do meet them. Although the efficacy of the treatment with anti-diphtheritic serum has been so thoroughly demonstrated (yet I regret to say there are still some reputable physicians who remain skeptic as to its beneficial influence, or are directly opposed to its use), its high standing as one of our most valuable of therapeutic agents will stand as a plea for its further mention in connection with this paper.

On the morning of January 5, 1900, I was called in consultation to see E. M., a little fellow three years old, who was first taken sick in the afternoon of January 1, complaining to his mother of a "stick in his throat"; he was seized with a hoarse croupy cough that evening, and coughed all night. The next morning the family physician was called in; he prescribed a wash for the throat. On the evening of January 4, the throat was ordered sprayed and a diagnosis of diphtheria was made. On the morning of January 5 a consultation was advised. At this time, when the diagnosis of diphtheria was confirmed, I found the little fellow suffering with an extreme laryngeal stenosis, as evidenced by marked dyspnea, cyanosis, anxious countenance and aphonia. There was no time to be lost. An injection of anti-diphtheritic serum (P. D. & Co.'s), 2000 units, was administered at once, and intubation urged. Upon the advice of the consulting specialist and operator, Dr. Joachim, tracheotomy was to be preferred. At 3 P. M., the time set for operation, the patient's condition was extreme; cyanosis had increased, and he was to all appearance moribund.

The administration of a general anesthetic was begun, but it was not found necessary to continue its use, mental stupor benumbing the sensibilities. During operation his condition had become so much worse, actual blueness of the face, abolition of corneal reflex and frothing at the mouth, symptoms of impending dissolution familiar to all of us, that we seemed to be working in forlorn hope. Immediately upon opening the trachea conditions changed, the patient quickly revived and color gradually returned to the face. The tracheal tube was ordered removed and cleansed every four hours. It was found at each cleansing to contain thick, adherent masses of membrane.

On the morning of January 6, twenty-four hours after the first injection of antitoxin, a second injection of 2000 units was

administered. The general condition of the patient improved slowly, but the local condition in the larynx still showed a great quantity of membrane, thick and adherent. On the third day a further dose of 1500 units of antitoxin was administered. Membrane gradually became less, but for safety's sake a fourth injection of antitoxin, 1500 units, was administered forty-eight hours after the third. The discharge from the tube now became a little more liquid, and patient's general condition continued slowly to improve, save for an ejection of the liquid nourishment taken by the mouth through the tracheal tube, due in all probability to a slight paralytic condition; the intubation position for feeding was suggested to obviate this, but the untrained nursing probably accounted for the failure to succeed even then.

A broncho-pneumonia now developed, but responded to treatment. The tube remained in the larynx about two weeks, at the end of which time it was removed, and the patient was discharged cured, save for the small laryngeal opening, which healed in due time.

Regarding the efficacy of antitoxin, authorities are pretty well agreed that after the fifth day of disease, except in very mild cases, and those almost tending to a spontaneous cure, it exerts very little or no influence, so that it should be used at once. A fact which has particularly impressed me in this case, as also in several others, is that as a rule we give the antitoxin in entirely too small doses. It will be seen that this little fellow was given 7000 units in four doses. Under similar conditions in the future, I shall probably not hesitate to give from 4000 to 6000 units as the initial dose; no harm results from its administration.

In an editorial on the dose of antitoxin, in *Pediatrics* for March 1, 1900, large doses are recommended, "3000 to 4000 units to a child under 2 years old. For older children and adults 6000 units as an initial dose is used; if after twenty-four hours improvement has not been manifested, we give 3000 or more units in addition. In deciding upon the amount to be given, besides the supposed duration of the disease, we are also influenced by the local lesions, and the amount of toxemia present." Considerable difference of opinion seems to exist as to the dosage of anti-diphtheritic serum. The article above quoted recommends large doses; in an article on "Diphtheria Antitoxin," in the

Medical News (April 14, 1900), the author states that English authorities recommend an initial dose from 6000 to 20,000 immunizing units, and not infrequently an initial dose of 50,000 units is given. He very aptly says that "the size of the English doses arouses a suspicion that the standard strength of the serum is low or that its strength is estimated differently than in other countries." On the other hand, in the same article, J. H. Musser is quoted as giving comparatively small doses, from 500 to 1000 units, respectively, to children below and above 8 years of age, repeated every six to twelve hours, if the condition of the patient does not improve. Here we are confronted with two extremes. Further statistics are necessary to draw an estimate of the proper dose. It has been my practice to give an initial dose of 2000 units in a case of pharyngeal diphtheria of ordinary severity; if after twenty-four hours conditions become aggravated this dose is repeated; if stationary and at the end of forty-eight hours improvement seems to be slow, a dose of 1500 units is given. At most two doses have usually sufficed in these cases. For laryngeal cases, in the future, I should not hesitate at an initial dose of from 4000 to 6000 units, repeated every twelve to twenty-four hours, as necessary. In these cases, particularly those of extreme gravity and requiring operative interterference, I am tempted to say that antitoxin might almost be given *ad libitum*. Age does not seem to be such a prominent factor in the determination of dose; the gravity of the local and constitutional conditions should be our chief guide.

In an article by Dr. T. H. Halstead on "Intubation in Diphtheria, Before and Since the Use of Antitoxin," the mortality table is striking. Whereas before the use of antitoxin the mortality of intubated cases of diphtheria was 76 per cent., with a percentage of recoveries of 24, in conjunction with the serum the mortality became 25 per cent., with 75 per cent. of recoveries. The average time during which the tube was worn in the cases which recovered was a little less than five days.

"As it requires from 18 to 24 hours for antitoxin to assert its beneficial influence, death before that time can hardly be attributed to the failure of the serum."

Comparing intubation with tracheotomy, the majority of operators seem to favor intubation. In the article quoted above the author says: "The great preponderance in America is in

favor of intubation. In Europe tracheotomy is the favored operation, but intubation has been gradually growing popular, until now it is rapidly replacing its older rival, and will doubtless soon occupy the position there which it does in this country."

The consensus of opinion seems to be in favor of intubation first; this failing of relief, tracheotomy. In the case in point, I believe intubation would have failed.

Again, and a fact which probably determined the operation in this case, intubated cases require more often trained assistance in nursing than do those of tracheotomy. Intubation being an operation difficult of performance except by one skilled in its practice, would predispose one in favor of tracheotomy in an emergency. It is not my province here to discuss the respective merits of intubation and tracheotomy; I have simply dealt in generalities. Further discussion I would submit to those better conversant with this subject, the laryngologists.

In conclusion, in this medical age, when we still employ in a great measure the expectant plan of treatment of disease, we should hail with delight such powerful allies which we possess in intubation or tracheotomy combined with the use of antidiphtheric serum in the treatment of severe diphtheritic, laryngeal stenosis.

II. The importance of the early diagnosis of hereditary syphilis becomes manifest to every physician at one time or another in his professional career. Unfortunately, the enthusiasm resultant upon the discovery of some latent condition in an obscure case, is often very short lived. We are prone to glide back in the rut of routine work and cease to be as diligent as we should in our search for causative factors. The frequency of a syphilitic foundation in the various chronic disorders of children is well known. Tuberculosis and syphilis are the extensive ground upon which the various chronic derangements of children are constructed. This is so, even though one out of every seven hereditarily syphilitic children die soon after birth. The existence of the latter frequently invites the co-partnership or the successorship of the former. Often in our search for hidden truths we fail to obtain assistance in the way of reliable antecedents. Again, frequently are the later symptoms of hereditary syphilis so irregular, or apparently typic of some other

condition, as will be shown by the report of the case in question, that we are unconsciously blinded to a realization of the actual underlying condition.

For the notes in the case I am about to report, I am indebted to Dr. J. Barnett, who was then interne of the children's service at the Charity Hospital. I regret exceedingly my failure to have taken photographs of this child before active treatment was begun, as more could be gleaned from them than from a written report.

Bessie G., aged 8 years, was admitted to the Charity Hospital on September 14, 1896, suffering with a very painful and fusiform swelling of both knee joints. Neither family history nor definite information concerning her then existing condition was obtainable. She had been an inmate of one of the orphan asylums of the city. Upon close examination the right knee joint was found the larger and more painful of the two. Her temperature was normal, and physical examination of the different organs revealed nothing wrong. The condition appeared so typic of a surgical tuberculosis that in the absence of any definite history a diagnosis of tubercular arthritis of both knee joints was made. Under chloroform anesthesia, the surfaces of both joints were scarified with the thermo-cautery, and the limbs immobilized in a plaster-of-Paris dressing. The little patient was given a tonic mixture of cod-liver oil, hypophosphites and lactophosphate of lime. This treatment, continued for some time, resulted in no benefit; in fact, she became progressively worse, as was manifested by the involvement of other parts of the body. About the middle of October (one month after admission), the left elbow joint was observed to be swollen and painful, and an ulcer, the sequel of a vaccination three weeks prior, notwithstanding all surgical precautions, had assumed extensive proportions by invading the deeper tissues of the arm. During the latter part of this month (October), the disease had further extended to the lower epiphysis of the radius of the same limb, and this was shortly followed by a dactylitis, involving the fingers of both hands. While these multiple lesions were manifesting themselves, the general condition of the patient had become much worse. The treatment of the various bone and joint lesions consisted in an immobilization of the parts. An anterior obtuse angular tin splint was applied to the

elbow, and the fingers of both hands were separately encased in plaster of Paris. About November 1 the surfaces of the knee joints were again scarified and the limbs encased in plaster. No improvement in the local condition was noted at this time. In view of the diagnosis of surgical tuberculosis, and fearing an involvement of the internal organs, particularly the lungs, from a further dissemination of the disease, a consultation resulted in the determination to institute more radical surgical measures. It was considered advisable to get entirely rid of as much of the diseased tissue as we consistently could. In view of the extensive involvement of the left upper extremity, elbow, wrist joint, fingers, and consequently so many separate foci, an amputation at the middle third of the arm was considered as probably the most expedient operation. Fortunately this was not carried out.

About the middle of November it was observed, upon closer scrutiny of the patient, that there existed a peculiar bridging of the nose, probably due to some pre-existing trouble of the nasal bones, and the square-shaped head, conditions frequently found in hereditary syphilitic troubles. It was accordingly decided that we tentatively institute antisyphilitic treatment, and observe the result. The patient was put upon a mixture containing $\frac{1}{72}$ of a grain of bichloride of mercury, 2½ grains iodide of potassium and 10 drops of syrup of the iodide of iron. The bichloride was gradually increased until a maximum dose of $\frac{1}{48}$ grain three times a day was taken. In due time favorable results were noted. Of the affected regions, the elbow was the first to respond, followed closely by improvement of the fingers; the right knee joint was somewhat tardy in improving. The vaccination ulcer, after the use of the specific treatment for but a brief time, assumed a more healthy aspect, and soon healed entirely. Apart from occasional slight derangements of the bowels, the improvement in both the local and constitutional conditions was steady and uninterrupted. The little patient left the hospital in a few months, comparatively well of her surgical condition, save for some swelling, pain and imperfect motion of the right knee joint.

Present Condition: I am happily able to present this little patient for your inspection to-day; have seen her to-day for the first time in nearly three years. As you will observe, she seems to be perfectly well. The surgical manifestations of her trouble

have entirely disappeared. The right knee joint, which was still somewhat swollen upon her dismissal from the hospital, has regained its normal size. The function of all the joints is perfect. Save for a continued anemia, she seems perfectly well.

As will be seen from the history, this case presented a typic picture of joint tuberculosis; there was present the fusiform enlargement of the joints, so characteristic of tuberculous. The dactylitis pointed more toward a tuberculosis condition. Syphilitic dactylitis is not a frequent manifestation, and is usually seen in children under five years old. As compared with tuberculous dactylitis, it is rare.

So much did the apparent pathognomonic picture of tuberculosis impress us, that it was only after failure of improvement and a retrogressive condition following prolonged treatment, in conjunction with an observation of the facies of the little patient, that we ventured tentatively on another line of treatment, with the result above shown. This should suggest the close scrutiny of all of our cases, more particularly those of an obscure nature; the possibility of a syphilitic taint should be borne in mind, especially in those cases resisting for some time the measures instituted for the relief of a supposed condition. No harm can result, and much good may, from the tentative use for a time, until definite results one way or the other are obtained, of specific remedies.

Clinic Lecture.

Specially reported for the JOURNAL from the Philadelphia Clinics.

TYPHOID FEVER COMPLICATED WITH PNEUMONIA.

BY PROF. ARTHUR V. MEIGS.*

This woman is 23 years of age, was admitted January 13. Nothing in the family history bears on the case. The history here says she had been ill for three weeks; had had headache, abdominal pain, constipation and some high fever and chills. For two weeks she had cough with rusty, blood-tinged expectoration and she was delirious at the time. When she was ad-

* From a lecture at the Pennsylvania Hospital.

mitted her temperature was 104 deg. and went up to 104⅗ deg., but has never been so high again. You may dismiss here the previous history of the patient, which is sometimes very important. In this case there is nothing at all that bears on the present attack.

For three weeks she was sick, and for two weeks she had this cough with expectoration, and sometimes she was delirious.

Now, the problem we have to solve is, to a certain extent, simple. It is evident there is some pulmonary disease, but we must not stop there. The question is, whether there is anything more, and this is perhaps a little difficult to answer. I do not call a temperature of 102 deg. very high and it does not take very much to get to 103 deg. But when we have 104 deg. it is more serious. She has had constant fever with a constant fall in temperature. Physical examination gave the following results: The pulse was dicrotic, the face flushed, she was stupid and mildly delirious, the tongue a little coated. Heart examination was negative; in the lungs anteriorly sibilant and sonorous râles were heard, posteriorly there were sibilant râles and at the base almost absolute silence. When she came in she was so sick that I did not care to keep her sitting up to make the refinements of diagnosis. The abdomen was a little distended and tympanitic. In the urin were a few granular casts and a trace of albumin. The history of the case and the progress are exactly such as would be indicated by the temperature sheet.

On present examination, the tongue is coated a little and a little disposed to be tremulous; the heart sounds are quite natural. There are still very considerable râles in both lungs anteriorly. When you listen at the base on the right, there is still absence of the breath sounds; numerous fine crackling râles and sonorous and sibilant râles. On the left the lung expands well; there are none of the fine crackles, but there are the sonorous and sibilant râles. It shows that the left lung is still somewhat filled up, though getting better. Dullness on percussion is greater at the right base than at the left.

The pulmonary condition is then as we have already said. Something in the physical condition of the woman there is which makes me question whether this is a simple attack of acute catarrhal pneumonia or whether it is an attack occurring in the course of typhoid fever; and it is a very common thing

for this to happen. The stupor was very striking. There was never any distinct rash, yet the stupor was marked and occasionally there was looseness of the bowels. She has had diarrhea, but very few stools, which we very commonly find in cases like this. I am satisfied that she had typhoid fever, and that she has had catarrhal pneumonia or broncho pneumonia as a complication.

In every instance where she has had a bowel movement it has followed an injection, but they have been soft and yellow. In cases of typhoid which are mild we commonly have no diarrhea, but have to give injections. She has had bowel movements every second day; and, even in the absence of spots, with the stupor and seriousness of the attack, I am satisfied it is not a simple broncho-pneumonia but pulmonary trouble as a complication in typhoid. "Broncho-pneumonia" is a good term because it brings to your mind a description of the case. In typic cases of typhoid fever we have bronchitis, and it is quite common for it to go on to pneumonia.

One thing more in regard to the diagnosis. We had the blood examined for its response to the Widal reaction, both by the board of health and our own laboratories. Both of the reports were positive. So that if you consider that of any value in diagnosis you have that in addition.

It is a curious thing how badly these cases get on so long as they are at their own homes. But when we put them in bed here and give them liquid diet and so on, it is wonderful how they get on. The treatment is simple: Keep her in bed, give her liquid diet, and, for medicinal treatment, carbonate of ammonia and Dover's powder. The typhoid fever here is not so important; if the woman is going to die, it will be from the condition of her lungs. As to the question of cold baths, I do not like too much cold water in pulmonary disease, and she has never been sponged, to say nothing of a cold bath.

Charity Hospital Notes.

Specially Reported for the JOURNAL.

AMPUTATION OF A FINGER WITH ITS METACARPAL FOR EPITHELIOMA BY NEURO-REGIONAL INFILTRATION ANESTHESIA.

FROM THE SURGICAL CLINIC OF DR. R. MATAS, PROFESSOR OF SURGERY IN THE MEDICAL DEPARTMENT OF TULANE UNIVERSITY, NEW ORLEANS.

There are three problems which in addition to the operative procedure itself present themselves to the surgeon for solution in every operation, viz.: abolition of pain, arrest of hemorrhage and prevention of infection. All these will be illustrated in the present instance, but the mode of abolishing pain, *i. e.*, the method of anesthesia, is the point to which I would especially direct your attention. The diagnosis is epithelioma of the dorsum of the hand, involving the base of the index over the first knuckle, and deeply infiltrating the subdermal tissues down to the palm. The patient is an aged farmer, nearly 70 years of age, who has suffered with this lesion for nearly a year. He is apparently strong, hale and hearty, with the exception of the present lesion. He has consented to the radical operation, which will involve the loss of the entire index, its metacarpal and a large portion of the integument of the dorsum of the hand, including a considerable area of the palm. The only hope of cure lies in a thorough extirpation of the diseased tissues, including a wide margin of apparently healthy tissue. The operation in this way is necessarily atypic and irregular in its outlines, and we can not follow any of the usually described or classical methods of amputation. This atypic character of the operation makes it more difficult to resort to local anesthesia by the usual procedures. But we shall endeavor to demonstrate that by anesthetizing the entire region or field of operation the operation can be performed with absolute painlessness without regard for the character of the anatomic parts involved. In order to accomplish this the neuro-regional method of infiltration with eucain B. will be applied. Eucain B. is preferred for all large or massive infiltrations because it is four times less toxic than cocain and can

be used very freely in one-fifth of 1 per cent. solutions. As much as 8 or even 10 ounces of this solution can be infiltrated into the tissues without fear of toxic consequences; this amount can be even doubled if the tissues are drained during the course of the operation, or in the instance in which the bulk of the injected fluid will be removed almost entirely in the course of the extirpation. In addition to this great advantage eucain can stand prolonged boiling and is itself slightly antiseptic. The eucain is dissolved in an eight-tenth of 1 per cent. NaCl steril solution. The addition of the salt to the solution is necessary to diminish the pain of the injection. Plain or distilled water causes pain by inhibiting swelling of the cells of the tissues; on the other hand any concentrated solution also causes pain by drawing water from the tissues. Solutions of the same specific gravity and of the same freezing point as the normal tissue fluids are the only ones which can be employed without causing pain from cosmotic disturbances and are called isotonic solutions. According to Heinze and Braun such a medium is an .8 per cent. solution when added to eucain B. in the proportion of 1:500. Hence the adoption of the solution. It is also very important to remember that the anesthetic effect of these weak anesthetic solutions does not depend exclusively upon the anelgestic substance employed but largely upon the physical effect of the solution itself which, when thoroughly infiltrated in the tissues produces ischemia, compresses the nerve filaments, and by lowering the temperature of the tissues, decidedly favors and intensifies the action of the narcotic drug. In order to still further intensify these physical effects of a massive infiltratiou we shall arrest the circulation after the injection by applying the Esmarch constrictor to the arm and also apply ice to the field of operation in order to refrigerate the solution. The skin being more sensitive the line of incision will be mapped out with a 1 per cent eucain solution. Then the general massive infiltration of the entire area will be made; but the injecting needle will be directed with special insistence in the region of the deep inter-osseous nerves as they lie on each side of the metacarpal that we propose to extirpate. Now you will understand why this method is called neuro-regional infiltration method. In this instance the infiltration will be made *para*-neurally, *i. e.*, in the vicinity and about the nerves, this

differing from the open intra-neural method in which nerves are actually exposed to view and interstitially injected. For injecting the skin an ordinary hypodermic syringe is used; for the more extensive infiltrating process a special apparatus resembling a Potain aspirator is employed in our practice. It consists of a common nursing bottle provided with a specially devised stopper through which is passed a double tube for connection with (*a*) a small air pump (Potain's), which is used to force air into the bottle until the necessary pressure is secured to overcome the resistance of the tissues, and (*b*) the needle for injecting the tissues. The bottle is partially filled with the solution and air pumped in, the stop cock cutting off communication with the air pump is closed and the pump detached. The bottle is then inverted and the cock of the tube communicating with the needle is opened. Thus the anesthetizing fluid flows into the tissues under the force exerted by the compressed air. By means of this apparatus large areas may be edematized with great rapidity.

The region of the operation, and especially the deep nerves, having been thoroughly infiltrated, the arm was elevated until depleted and the Esmarch constrictor applied. The skin was benumbed with ice. In a few seconds the line of amputation and excision involving a large irregular area of the dorsum of the hand was mapped out, the base of the second metacarpal close to the wrist was exposed and sawed off with a Gigli saw; the finger and other parts were then rapidly excised. The operation was accomplished without the slightest degree of pain.

N. O. Medical and Surgical Journal.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

Editorial Department.

PAN AMERICAN MEDICAL CONGRESS.

The Cuban Organization Committee decided to postpone the date of assembly of this congress, which was to have taken place in December.

This was done because it was feared that the dread of yellow fever might to some extent diminish the attendance from this country.

The exact date has not yet been announced, but it will probably be from February 5 to 9, or from February 12 to 16.* We would prefer the former and take this occasion to urge it upon the committee, as it would give to the returning members a better opportunity of reaching New Orleans in ample time to enjoy the carnival festivities culminating on Mardi Gras, February 19.

We hope a large number of the delegates and members will arrange their itinerary so as to include this city at least on their return. It can be reached by the all steamer trip in 60 hours and by the chiefly rail route in much less time. The season is usually pleasant at that period, and those who come through will no doubt be tempted to tarry a while, and will surely be delighted by the pre-lenten celebration.

The success of the congress seems to be assured, as already more than two hundred delegates have signified their intention of attending, and over one hundred papers from this country have been promised to the different sections.

As the time for decision and preparation is still ample, we hope that many from this city and section will make up their minds to attend.

* Since the above was written, the date has been fixed, February 4 to 7.

THE NEW YEAR.

The year just past has witnessed the advance along all lines of medical research, and perhaps the most potent and remarkable of the newer methods are those which have been deduced from natural forces. The year has seen the confirmation of the mosquito theory of malaria; it has demonstrated the applicability of liquid air in the treatment of new growths; spinal anesthesia has been popularized; the Finsen light treatment of lupus is established, and the X-ray has become potent in diagnosis and even useful in the treatment of some types of diseases. More and more as the days have gone by has serum treatment been advanced in general use, until, at this beginning of the twentieth century, we see a group of diseases fought by the products of their own origin—diphtheria, cholera, tuberculosis, plague, leprosy, tetanus, septicemia—while yet on the way to join this formidable host are the yellow fear, cancer, typhoid and others.

The evergrowing differentiation in disease makes the need of remedy more important, and the year has been flooded with new drugs, some good, some bad, but all cast into the crucible of usage to survive or to fall in time.

The demands of civilization in its various processes annually sacrifice a mass of human lives, unable to withstand either the force or the effect of the process. While the great economic law compels a fixed relation in the disposition of sustenance and those sustained, still we struggle in the hope that single handed we may save a life here and there in the great panorama of the passing show. This New Year begins a new century and one promiseful of great things in the world's achievements. To have forecast one hundred years ago the events of the last quarter of a century would have been impossible. To forecast the greatness of coming events would likewise be impossible, and yet all steps, mighty or minute, lead to a finite end. The progress of the world must continue until it stops. The pace which science in all its field of effort has set points to the absolute verity of the dictum that no matter how fast a horse may run it can not run a mile in nothing.

But while we of a semi-scientific profession keep in the procession, let the new century bring with it the desire to each man to keep in the vanguard, where, whatever the obstacle, it may be well in front.

Abstracts, Extracts and Miscellany.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans, La.

Placental Transmission.—Dr. W. A. N. Dorland concludes an article in the *American Gynecological and Obstetrical Journal* on the subject of placental transmission as follows:

1. While many drugs may be administered to the mother without any noticeable effect upon the fetus, there are certain substances that show a special tendency to traverse the placenta and entering the feto-placental circulation, exert a positive influence for good or evil, according to the condition that may be present in a given case.

2. Maternal medication, therefore, is indicative in certain conditions, either in order to prevent the development of a similar condition in the fetus or to counteract the effects of germs and their toxins already introduced in the fetal economy.

3. The drugs that have been found to affect the fetus in utero are notably opium, mercury, copper, lead, arsenic and the iodides. In appropriate doses they may be administered to the mother in suitable pathologic conditions with beneficial results to both mother and child.

4. Any morbific influence acting upon the mother either acutely as in the case of the exanthemata, or more slowly, as in tuberculosis and specific infection, will react deleteriously upon the product of conception, and either destroy it through its overwhelming toxic action or render it feeble and less resistant to subsequent and post natal invasion or the disease will run an atypical course in utero with or without apparent vestiges at birth.

5. The entrance into the fetal structures is accomplished through the agency of the feto-placental circulation. It is probable that access is gained through bacterial action, the

germs rendering the placental villi less resistant to invasion, whereby both the microbes and their toxins pass the natural barrier at the chorio-decidual junction.

6. As a rule, the infectious diseases do not manifest their characteristic visceral lesions in the fetus, probably because of the passivity of these organs during antenatal existence.

3. The germs, however, may be detected in large numbers by bacteriologic and microscopic examination.

THE REMOVAL OF PELVIC INFLAMMATORY MASSES BY THE ABDOMEN AFTER BISECTION OF THE UTERUS.—Recently Howard A. Kelly pointed out the great advantages which accrued from bisection of the myomatous uterus in an abdominal enucleation in certain complicated cases. The *Nashville Medical and Surgical Journal* for November contains an article read before the Southern Surgical and Gynecological Association at Atlanta, November 12, in which Dr. Kelly called attention to the great value of a somewhat similar procedure in certain cases of pelvic inflammatory diseases. The steps of the operation are as follows: If the uterus was buried out of view, the bladder was first separated from the rectum and the fundus found. Then, if there were any large abscesses, adherent cysts, or hematomata they were evacuated by inspiration or puncture. The rest of the abdominal cavity is then well walled off from the pelvis. The right and left cornua uteri were each seized with stout Museaux forceps and lifted up, the uterus incised in the median line in an antero-posterior direction, and as the uterus was bisected its cornua were pulled up and drawn apart.

With a third pair of forceps the uterus is grasped on one side of its cut surface, as far down in the angle as possible, including both anterior and posterior walls. The Museaux forceps of the same side are then released and used for grasping the corresponding point on the opposite cut surface, when the remaining forceps are removed. In this way two forceps are in constant use at the lowest point.

As the uterus is pulled up and the halves become everted, it is bisected further down into the cervix. If panhysterectomy is preferred, bisection is carried all the way down into the vagina. The uterin canal must be followed in bisection, if necessary use the grooved director. The forceps are then made to grasp the uterus well down into the cervical portion. If

supra vaginal amputation is preferred, the cervix is bisected on one side. As soon as it is divided and the uterin and vaginal ends begin to pull apart, the under surfac of the uterin end was caught with forceps, pulled up, and the uterin vessels exposed. These are clamped or tied.

As the uterus is still pulled farther up the round ligament is exposed and clamped, then finally a clamp is applied between the cornua of the bisected uterus and the tubo-ovarian mass, and one-half of the uterus removed. The opposite half of the uterus is treated in a similar way. Nothing is then left in the pelvis but the rectum and bladder with the tubo-ovarian masses plastered to the sides of the pelvis and broad ligaments affording abundant room for investigation of their attachments and dissection. The wide exposure of the cellular area over the inferior median and anterior surfaces of the masses offer the best avenue for beginning their enucleation. After bisection of the uterus it is sometimes possible to remove the corresponding tube and ovary with its half, leaving separate enucleation for the more difficult cases. The operation is not recommended to a beginner in surgery.

The advantages of this method are additional space for handling adherent adnexa, great increase in facility for dealing with intestinal complications, access by new avenues from below and in front to adherent lateral structures, elevation of structures to or above the pelvic brim, or out of the abdomen for manipulation and dissection, and advantage of approaching the uterin vessels by cutting across the cervix instead of in continuous transverse incision. The surrounding structures are far less liable to injury, there are fewer troubles and sequelae, and the mortality is lessened.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Bloodletting and Subcutaneous Salin Infusions in Grave Toxic and Infectious Conditions.—Aside from the indication to grapple directly with the cause of the disease, another indica-

tion, just as important, presents itself in such cases, namely, to remove from the organism the greatest amount possible of poisons by a simultaneous action on the kidneys and the blood, and to render these poisons less dangerous by diluting them in the blood.

Bleeding rids the latter of a great number of toxins. When performed moderately it also increases the fulness and the force of the pulse. It facilitates the work of the heart, restores the weakened contractility of the peripheral capillaries, while it favors the gaseous exchanges as a result of its stimulant effect on the activity of nutrition. But the action of bleeding, which is often most powerful, is merely transitory, since the toxic fluids impregnating the tissues are drawn into the circulation to replace the abstracted blood and again constitute a part of it. Barré, moreover, demonstrated that in some degree, diuresis is lessened as a result of the lowered vascular tension. Now then, by injecting into the subcutaneous tissues a salin solution we can raise the blood pressure, augment the flow of urin and stimulate the cells, in other words, we by this means actually fortify the natural defense of the organism. It is obvious from what has been said that more rapid results should be obtained by the use of the hypodermic infusion in association with venesection. This combination can be carried out after two methods: 1st, that of de Bosc, namely a moderate bleeding (150 to 400 *c. c.*) followed by a large (600 to 2500 *c. c.*) intravenous or subcutaneous saline infusion; 2nd, that of Barré, namely a large bleeding performed simultaneously with an equal amount of salin infusion.

Georges Raynaud of Marseilles, the author of the present report, has employed in general de Bosc's method, while he employed that of Barré in cases of marked adynamia and hypotension. The solution used was made according to the formula of Hayem's artificial serum, namely:

Sodium chloride	7 grams.
Sodium phosphate	2 grams.
Sterilized water	*q.s. ad* 1000 *c. c.*

More often the solution was simply made with 7 grams of sodium chloride and 1000 *c. c.* of sterilized water.

Raynaud reports his results in cases of auto-intoxications, exogenous intoxications and infections.

It is impossible to make a résumé of his clinic and statistic work, and the effects noted by him are simply indicated here:

Immediate effects. When no more than 500 *c. c.* were infused, during the performance of the operation, no change occurred in the general condition, seldom did a slight thermic reaction take place. When more than 500 *c. c.* were infused, the pulse became more full, the blood pressure, if low, was raised. As to the temperature it rose during the five successive hours, not so when bleeding was performed simultaneously with the infusion. The flow of urin was abundant, the elimination of urea and chlorides rapidly increased. The quantity of hemoglobin, at first lowered, soon augmented.

Remote effects. The thermic line often fell; the convalescence was rapid.

Raynaud prefers the subcutaneous to the intravenous infusion, the effects being somewhat less speedy, but just as complete and lasting. The conclusions reached by Raynaud are based on important and conscientious statistics, the value of which can not be questioned.—*Gazette des Hôpitaux*, October 20, 1900.—*Archives Provinciales de Medicine*, March, April, May, June, 1900.

Rice for Feeding Cases of Gastric Ulcer.—Bourgeat, professor on clinical medicine at Lausanne (Switzerland), holds that milk, usually prescribed in cases of gastric ulcer, is far from being the ideal food for such cases, though it eases the pain for a while. Milk evidently dilutes the gastric juice and lessens it acidity; but this effect is so transitory that three to four hours after the ingestion of milk, from 0,4 to 0,5 per 100 of free hydrochloric acid are yet found in the contents of the stomach. Should there exist, moreover, any spasmodic condidition of the pylorus, milk becomes a source of gastric fermentations. Finally, in cases taking exclusively milk, the stomach does not hold enough proteids to neutralize the free muriatic acid which then irritates the mucosa and rouses and quickens pain. The latter fact has pressed upon Bourgeat the idea of substituting for the exclusive milk diet, a porridge of rice cooked with milk during the acute period of gastric ulcer.

The following is the manner of preparing the food:

Boil for several hours 50 grams of rice in a litre of milk, then keep the mixture in a water-bath until it takes the consistency of a thick pap.

This preparation affords a nutritious meal, non-irritant to the stomach, capable of neutralizing the free muriatic acid, without remaining beyond a beneficial limit of time in the gastric cavity. In the first few days neither salt nor sugar is added, but this can be done to suit the patient's taste when the ulcer's cicatrization seems assured.—*Gazette des Hôpitaux*, October 20, 1900.—*Journal de Médecine de Paris*, October 7, 1900.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Myrtol.—Solis Cohen, in *Merck's Archives* for November, 1900, says: "The happiest results that I have seen from its use have been in the relief of obstinate cases of bronchorrhea, dilated bronchi, fibroid tuberculosis with bronchiectatic cavities, and in bronchitic asthma. In all these groups of cases there have been failures as well as successes, but myrtol seems to have the power in most cases of promoting healthful and diminishing unhealthful secretions. Thus, in some cases of asthma in which the paroxysms have seemed to be brought about by the effort to dislodge secretions not sufficiently moist to be easily expectorated, the administration of myrtol has seemed to increase the ease of expectoration, while later diminishing its frequency and the quantity of expectorated matter."

"The dose is about the same as that of turpentine, terebene, or sandalwood oil—that is to say, from 5 to 15 minims, given from two to five times in the course of the twenty-four hours. For purposes of study, myrtol has been given without any other medicament in order not to confuse the result; in practice it may be variously combined. When uncombined, it may be given in emulsion, or dropped upon sugar, or placed in sealed

capsules, and if given in capsules it is well to have the patient take a little milk afterwards. In other words, the drug is to be handled as one handles turpentine. It may be used likewise for inhalation in any convenient way, and its inhalation often serves to relieve cough and promote expectoration in chronic affections of the air passages."

Sodium Meta-Vanadate has been carefully investigated by Drs. Lyonnet, Martz and Martin. It is a powerful oxidizer, and to this property it most probably owes its therapeutic virtues. It was given to adults in doses of $\frac{1}{120}$ to $\frac{1}{60}$ grain twice a day. Marked increase in appetite and strength and general improvement in well-being were noted; in several patients there was considerable increase in weight. These results were most marked in cases of anemia and tuberculosis. Its stimulating action on nutrition disappears rapidly if the drug is given continuously; they, therefore, advise to give it intermittently two or three days in the week. Physiologic investigations have shown that the drug did not act directly on the blood; the corpuscles were not changed, the hemoglobin was not increased or diminished; the circulation was not much affected. The drug was eliminated through the kidneys only to a slight extent. The toxic dose is about 8 centigrams ($1\frac{1}{3}$ grain) for each kilo ($2\frac{1}{5}$ pounds) of body weight.—*Merck's Archives.*

The Treatment of Whooping Cough with Antitussin.—Dr. Max Hein, writing in the *Berliner Klinische Wochenschrift*, says: "A new remedy has been recommended in whooping cough, an organic preparation of fluorin, known as antitussin. Whilst I must confess that, at first, I could not accept this remedy with great expectations, I must now admit, after extensive observation that, it is the most valuable remedy for whooping cough that we possess at present.

"I have tested the efficacy of antitussin thus far in about 16 cases, some of them very severe ones. It failed in not one instance, even in the severest case. Several times after the above-mentioned remedies had failed (quinia and belladonna) antitussin uniformly achieved the desired result.

"Antitussin is an ointment composed of difluor-diphenyl, 5 parts, vaselin, 10 parts and 85 parts of chemically pure wool fat. According to Tischer and Beddies, antitussin (difluor-

diphenyl) diffuses readily through animal membrane just like the other fluorin preparation (fluor-pseudocumol 1 part, difluor-diphenyl 4 parts.) In the form of ointment, these are well taken up by the skin, especially so antitussin.

"Furthermore, fluorin in organic combination is comparatively but slightly toxic, after topical application its presence in the urin is readily demonstrable.

"Antitussin is applied externally only, since the fluorin preparations may in some instances influence digestion unfavorably. It is used thus:

"Neck, chest and back between the shoulders are thoroughly cleansed with warm soapsuds and thoroughly dried with a rough towel. Then antitussin, as much as a hazel nut, is spread over the prepared surface and energetically rubbed into the skin with the palm of the hand. Inunction is to be performed in the manner of massage, and must be continued until entire disappearance of the ointment is perceptible to the hand."

Observations on Gelatin Injections for Aneurism.—In the *Interstate Medical Journal* for September, 1900, Nietert, after detailing the use of this treatment in a series of cases concludes:

1. Great pain at site of injection often follows introduction of a large amount of the fluid.

2. The gelatin being a good medium for the development of micro-organisms, great care is required to keep it sterile.

3. The symptomatology is greatly improved in every case; the pain is usually lessened, patient breathes easier and shows less pressure symptoms on important surrounding organs.

4. In most cases tumor becomes more firm and expansibility less marked.

5. It is likely that great good can be effected by the gelatin injected in aneurism of the smaller vessels.

6. *Post-mortem* examination in every case showed large organized clots, filling the cavity of the aneurism, which were undoubtedly due in a great measure to the gelatin.—*The Therapeutic Gazette.*

Loss of Hair.—Jackson (*Edinburgh Medical Journal*, October, 1900,) states that if we can cure dandruff the loss of hair is checked, unless the scalp has been too much damaged by the

atrophic processes to which it gives rise. He has had positive results in checking the fall of hair and increasing its amount by using precipitated sulphur 10 per cent. in a good cold cream with or without either salicylic acid, 3 to 5 per cent., or extract of jaborandi one drachm to the ounce. The ointment proposed by Bronson, composed of ammoniated mercury twenty grains, calomel forty grains, in one ounce of vaselin, has also done good service in some cases. Sometimes resorcin in solution and in increasing strength has proved helpful. On the other hand, naphthol and cantharides have been complete failures; in many cases none of these have aided. The dandruff being parasitic in origin, is apt to relapse, hence the remedies are to be resumed should it reappear. For stimulating the growth of hair the best remedy is massage, but this must not be resorted to until the dandruff has disappeared. The services of a skilled professional give the best results, but good may be done by the patient himself pinching up the scalp between the ends of the extended fingers of both hands five minutes twice a day.—*The Therapeutic Gazette.*

Acute Bronchitis—

℞ Terebene ..... 2 dr.
Morphin sulphate ..... ½ gr.
Syrup Tolu ..... 1 oz.
Mucilage acacia ..... 2 oz.
Teaspoonful every three hours.

—Da Costa.

℞ Ammonium chloride ..... 80 gr.
Tartar emetic ..... 1 gr.
Potassium iodide ..... 16 gr.
Simple elixir ..... 2 oz.
Distilled water ..... to make 8 oz.
Tablespoonful every three or four hours.

—*New Eng. Med. Monthly.*

Early Cough and Fever in Pneumonia—

℞ Potassium citrate ..... 6 dr.
Spirit nitrous ether ..... 4 dr.
Camphorated tinct. opium ..... 4 dr.
Solut. potassium citrate ..... to make 6 oz.
Dessertspoonful every three hours.

—Hughes, *St. Louis Clinique.*

Acute and Chronic Coughs—

℞ Linseed oil ..... 15 oz.
Oil wintergreen ..... 2 dr.
Oil cinnamon ..... 2 dr.
Dil. Hydrocyanic acid ..... 2½ dr.
Glycerin ..... 5 dr.
Simple syrup ..... 10 oz.
Water ..... 24 oz.
Irish moss ..... ½ oz.

Make an emulsion; 2 to 4 teaspoonfuls three times a day.

—Wm. H. Thompson.

(The editor of *Merck's Archives* says "we have tried the above in a great number of instances, and found it a most excellent combination. When the cough is very irritating and painful, 1-6 grn. codein or 1-6 gr. dionin may be added to each dose with great advantage").

Department of Ear, Nose and Throat.

In charge of Dr. A. W. DeRoaldes and Dr. Gordon King, New Orleans.

Vibratory Massage by Means of a Sound in Diseases of the Upper Air Passages.—Dr. Michael Braun, of Trieste. highly recommends a method which he has adopted for the treatment of various affections of the nose, throat and ear, which consists in a simple process of massage of the mucous membrane carried out by means of a flexible sound operated by hand. The sound is shaped to correspond to the anatomic relations of the part to be treated and the mucous membrane subjected to brisk friction with the instrument, which the author claims tends to equalize the circulation in the parts and reduce undue congestion. For the relief of severe migrain, such as is often associated with some abnormal condition of the accessory cavities of the nose, the nasal mucosa, especially in the middle and superior meatus, is frictioned briskly with the instrument for five or six minutes, every day, and is claimed to have given relief to a large number of the cases. Deafness is treated by massage of

the mouths of the Eustachian tubes and by rubbing the external ear and temporo-mastoid region with the hands. The author reports two cases of marked deafness much improved by this method when other measures had failed.—*Archives Internationales de Laryngologie, etc.*, September and October, 1900.

Treatment of Nasal and Naso-pharyngeal Affections by Applications of Hot Air.—This method as described by Lermoyez and Mahu of Paris consists in applying directly to the mucous membrane currents of dry air heated to a temperature of 80 to 100 degrees centigrade. The air is kept in a metallic receptacle under pressure of 120 atmospheres and is heated to the desired degree in its passage through a spiral tube. Suitable canulæ are fitted to the conducting tube for application to the special parts with an attachment for regulating the temperature and pressure. The applications are made under light, the seances lasting two minutes and repeated two or three times a week.

Usually ten or twelve applications are required to give a definite result, and no pain is experienced by the patient.

The first effect on the mucous membrane is to cause an intense retraction followed soon by an abundant flow of mucus.

The treatment is especially efficacious in chronic congestive coryza with intermittent nasal obstruction, spasmodic coryza, nasal hydrorrhea, otalgia, deafness and tinnitus associated with naso-pharyngeal catarrh. In ozena, purulent rhinitis, lupus, and hypertrophic rhinitis the results are not favorable. —*Ibid.*

A Tooth Growing from the Orbital Wall of the Maxillary Sinus.—G. Liaras reports the following peculiar case observed in the service of Dr. Moure, of Bordeaux: A man, 45 years of age, came to the clinic with evidences of an empyema of the left maxillary sinus. An opening was made through the canine fossa, and a quantity of pus evacuated. The opening having been left unclosed, an examination of the cavity a few days later revealed the presence of a well developed molar growing from the orbital wall of the cavity. It apparently had no part in the causation of the empyema which began as an abscess at the root of one of the teeth in the mouth, and its removal was not thought advisable. One of the upper molars was absent on that side.—*Revue Hebdomadaire de Laryngologie*, etc., October 27, 1900.

Tonsillitis.—J. A. Abraham, in the *Medical Record*, November 3, 1900, gives the following formula for the treatment for acute tonsillitis:

℞ Formalin ..... ♏ xv.
Potass. Chlorat. ..... ℥ i.
Liq. Ferri Chlorid. ..... ℥ i.
Aquae Menth. Pip. ..... ℥ iv.
M. Sig. Apply or spray in throat every hour.

Internally:

℞ Quin. Hydrobromat. ..... gr. i.
Sod. Benzoat. ..... gr. ii.
Salol. ..... gr. v.
M. Sig. Take every three hours.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

Use of Potassium Iodide.—In a well-written paper on the use and abuse of potassium iodide in ophthalmic practice, Dr. Albert Rufus Baker, of Cleveland, O., comes to the following conclusions:

1. Iodide of potassium should generally be administered in rapidly increasing doses until from 1 to 500 grains are given daily.

2. The drug should always be given after eating, and well diluted with water.

3. Frequent hot baths are essential to the best results in the use of the remedy.

4. Not infrequently large doses will be tolerated when smaller ones can not be well taken.

5. The use of the large dose is not limited to syphilitic cases.

6. Large doses are indicated in optic neuritis, ocular paralysis, choroiditis, serous iritis and in relapsing iritis, cyclitis and interstitial keratitis.

7. It is contraindicated in gray atrophy of the optic nerve (spinal atrophy—Ed.) and in most cases of postneuritic origin.

8. Albumin in the urin, generally speaking, is a contraindication for large doses of iodide.

9. Young children do not take the iodide kindly and it sho uld be administered cautiously.

10. The remedy is of doubtful value in early syphilitic iritis.

11. Large doses are of doubtful utility in the removal of post-operative exudates, but should be given further trial.

These conclusions tally with our well matured experience. Especially do we desire to emphasize the necessity for large doses. The drug should be pushed to the very limit of toleration in each individual case, but unless we can manage that at least one drachm shall be taken three times daily, we have observed none of the brilliant benefits that it is often capable of bestowing. Administration after meals and in high dilutions usually renders it tolerable, especially together with tactful encouragement and patience. Dr. Baker speaks highly of a teaspoonful of the following, as a menstruum for the saturated solution:

℞ Hydrg. chlor. corros	gr. i
Potass. iodid	ʒi
Tr. cinchonæ comp.	ʒij
Aquæ q. s. ad.	ʒiv

(From a paper read before the section on ophthalmology of the American Medical Association.)—*The Journal Am. Med. Assn.*, Nov. 17, 1900.

Etiology and Treatment of Chalazion.—In a paper on this subject Dr. Stazmenski, of Wilna, concludes, after discussing the views of a number of prominent investigators, that the cause of the affection consists in the penetration of microbes (bacilli resembling the tubercles of Koch and Cocci) into the meibomian gland of the conjunction and of the ciliary margin of the lid. The tubercular origin of chalazion is rejected by him as well as by a majority of authors, except in very rare cases as instanced by Fangl's case. The treatment employed by him for five years in 119 cases regardless of cause, consists in applying an ointment upon the skin surface of the chalazion and rubbing it in gently every night at bedtime. The formula for the ointment is as follows:

Pure iodin	gr. iii
Iodide of potassium	gr. ix
Lanolin	ʒi
Liquid vaselin	gr. xii
Distilled water	gr. xii

The results obtained were convincing of its efficacy in so much as 63 per cent. of the cases were cured without surgical interference.—*Receuil D'Ophthalmologie*, August, 1900.

Miscellaneous.

THE PHYSIOLOGIC STANDARDIZATION OF DRUGS.—An appeal to the intelligence of the medical profession has been made by Messrs. Parke, Davis & Co., and with so much logic that we feel it is important that the profession should share with us the appreciation of their argument. This concern has done a great deal for the medical profession, and the general recognition of the importance of physiologic standardization is especially to their credit.

"What right has any firm, whose business is to furnish the physician with his principal weapons, to place upon the market pharmaceutic preparations of unknown medicinal value? Should we not expect, yes, even demand, that the producer of fluid extracts make his products conform to some standard of excellence—that he shall indicate what effects his fluid extracts may be expected to have ere he sends them forth from his laboratory?

"It has been shown that even drugs selected with care vary most extraordinarily in their percentage of active principles. Witness, for example, this statement by the editor of a leading pharmaceutic journal, *Bulletin of Pharmacy*, who knows whereof he speaks:

"'Professor Puckner assayed nineteen samples of belladonna leaves procured, mind you, from dealers who were told that only the best was wanted, and that purchase would depend upon the results of assay. He found these nineteen samples to range in alkaloidal content from .01 to .51 per cent. The strongest sample fifty-one times as strong as the weakest.'"

"The most careful treatment of such drugs, with the choicest menstrua, and by the most approved processes, will yield preparations that may be fair to look upon, but in medicinal value they will vary just as much as the crude drugs from which they are

made. The compensatory remedy for this unfortunate condition is standardization—chemic standardization when practicable, and when that method is inadmissible, as it often is, physiologic standardization. It has been found that certain important drugs can not be assayed chemically, as their medicinal virtues reside in unstable bodies, and these are readily decomposed in the analytic processes. For this reason the strength of such powerful and useful drugs as digitalis, aconite, convallaria, strophanthus, ergot, cannabis Indica and many others can not be determiued satisfactorily by the analytic chemist. However, the problem which proved to be an insurmountable difficulty to the chemist, was solved by the pharmacologist with ease. He tests upon living animals all drugs that can not be assayed chemically. Dogs, rabbits, fowls and guinea-pigs receive doses of the preparations under examination. Accurate observations of their physiologic effects are made, variations are noted and corrected, until the preparations correspond in medicinal strength with the adopted standard extracts.

"Formerly the physician was obliged to make his own physiologic tests of ergot, digitalis and so on; not upon dogs and guinea-pigs, however, but upon his patients. The old way was to begin with small doses of powerful drugs and then to push them until the desired effect was produced. The new way is a much better one, it is safer for the patient, more satisfactory to the physician, and it is more scientific. Prompt results are assured, for the physician knows just how much fluid extract of ergot, aconite or cannabis Indica he need include in his initial dose to secure a definite result."

Louisiana State Medical Society Notes.

The next meeting of the Society will be held in New Orleans, April 18 19 and 20, 1901. Dr. F. W. Parham, New Orleans, President; Dr. H. B. Gessner, New Orleans, Secretary; Dr. Isadore Dyer, 124 Baronne street, New Orleans, Chairman Committee of Arrangements.

The Committee of Arrangements urges all chairmen of sections to prepare their subjects for general discussion; the following have already been announced:

Section on Surgery.—Dr. E. D. Martin, Chairman, New Orleans. Subject for general discussion, Treatment of Fractures of the Long Bones of the Upper and Lower Extremities.

Section on Materia Medica and Therapeutics.—Dr. L. Sexton, Chairman, New Orleans. Subject for general discussion, Is the Tendency Towards Prescribing Proprietary Medicines Increasing; Its Final Effect upon the Professions of Medicine and Pharmacy.

Section on Ear, Nose and Throat.—Dr. O. Joachim, Chairman, New Orleans. Subject for general discussion, The Middle Ear Inflammations of Childhood and their Consequences.

Section of Ophthalmology.—Dr. E. A. Robin, Chairman, New Orleans. Subject for general discussion, When Not to Operate in Anomalies of the Extrinsic Muscles of the Eye.

Section on Dental and Oral Surgery.—Dr. A. G. Friedrichs, Chairman, New Orleans. Subject for general discussion, The Care of Children's Teeth.

Titles of all papers of the above sections, whether on the general subject for discussion or other subjects, should be sent to the Chairman of the Section or to the Chairman of the Committee of Arrangements, so that they can be duly and properly placed on the program.

MEMBERS OF THE SOCIETY are earnestly requested to furnish the JOURNAL with items of interest about themselves, other members of the Society, or the Society itself, for publication in this department.

Medical News Items.

THE ORLEANS PARISH MEDICAL SOCIETY, at its meeting December 8, elected the following officers for 1901:

Dr. E. D. Martin, president; Dr. H. B. Gessner, 1st vice president; Dr. L. G. LeBeuf, 2nd vice president; Dr. Geo. Stumpf, 3d vice president; Dr. W. M. Perkins, recording secretary; Dr. M. H. McGuire, treasurer; Dr. S. P. Delaup, librarian and corresponding secretary; additional members to complete board of directors: Drs. John Callan, H. D. Bruns and T. S. Dabney.

The inauguration meeting will take place Saturday evening, January 12, 1901.

The Medical Society of the State of New York will hold its ninety-fifth annual session in Albany, January 29, 30 and 31, 1901, under the presidency of Dr. A. M. Phelps, of New York City.

The Samuel D. Gross Prize of One Thousand Dollars.—No essay which the trustees deemed worthy of the prize having been received on January 1, 1900, they hereby announce that the prize will be awarded on October 1, 1901.

The conditions annexed by the testator are that the prize "shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the competitor who receives the prize, shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page, it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 219 S. 13th St. Philadelphia," on or before October 1, 1901.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

W. W. Keen, M. D.,
J. Ewing Mears, M. D.,
J. Chalmers da Costa, M. D.,
Trustees Philadelphia Academy of Surgery.

The Cultivation of Ginseng in the United States is projected on a large scale, as the circulars of a Boston concern would indicate. The far East is beginning to demonstrate that "some good can come out of Nazareth."

The Louisiana State Public School Teacher's Association presented an excellent program for their meeting at Alexandria on December 27 and 28.

A Donation of $50,000 to the College of Physicians and Surgeons of Chicago has been made by Drs. Wm. E. Quine and D. O. K. Steele, both members of the faculty. The amount was given in the sum of $25,000 by each, the funds to go to the college library and the pathologic department respectively.

The donations are conditioned upon the purchase of the University of Illinois by the trustees, but this is said to be already nearly effected.

Mortuary—Dr. L. M. Finney, assistant coroner under the last administration, died at his home in New Orleans, November 28. The Journal condoles with the bereaved family.

The death of Dr. Paul Gibier, in June last, has not stopped the publication of the *Bulletin of the Pasteur Institute*, established by him. In the September number of this periodic, a touching tribute is editorially given and a review is made of the work of Dr. Gibier in a life as diversified as it was intense.

Diploma Mill in Chicago Stopped.—"Doctor" James Armstrong, president at various times of the Metropolitan and Independent "Medical Colleges" and the "Illinois Health University," was to-day sentenced by Judge Kohlsaat to serve one year in jail and pay a fine of $500. Armstrong was found guilty of using the United States mails to defraud. Testimony adduced at the trial showed that Armstrong's institutions were devoted entirely to the selling of diplomas.

It will be remembered that the Illinois authorities have been laboring some time to effect the above end.

The Roentgen Society of the United States presented an attractive program at their recent meeting in New York City. The papers submitted related chiefly to skiagraphy and to the use of the X-ray for diagnosis.

The Charity Hospital Training School for Nurses held an interesting commencement during the past month.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Diabetes Mellitus and Glycosuria. By Emil Kleen, PH. D., M. D. P. Blakiston's Son & Co., Philadelphia, 1900.

The work comprises nine chapters, beginning with the Definition and History, and ending with the Treatment of Diabetes. A few pages in the latter part of the book are devoted to a table of the commonest kinds of food, showing constituent percentages of proteid, fat, and carbohydrate.

The history given embraces a rapid survey of the subject from the time of the Roman Celsus, to whom the origin of the term is attributed, up to the year 1900. Mention is made of the fact that during the seventh century, as now, the disease was more general among the Hindus than among other races.

The works of Rollo, Cruikshank, McGregor, Simons, Tledmannt Guelin, Magendie, Frerichs, Claude Bernard, Traube, Brücke, Bence Jones, Gerhardt, Schmidt, Bischoff, Reiset, Reignault, Pettenkofer, Voit, Rubner and others are passed over in rapid review. Attention is also called to the extensive literature which has accumulated during the last few decades, through the energy of Bouchard, Seegan, Pavy, Hoffmann, Gressinger, Kütz, Ebstein, Kaufman, Lépine, and others.

The fact that diabetes is common among people of nervous temperament presented by means of statistics, and it is shown that, next to the Hindus, the Jews are highest in the scale of diabetic frequency. We quite agree with the author that there is a strong probability that diabetes is a predisposing cause of Reynaud's disease. Our experience leads us to believe that carbuncle is associated with diabetes more frequently than is stated by the author; namely, 2 or 3 per cent.

We are of the same opinion as the author, regarding the presence of sugar in minute quantities in normal urin, and feel that great care should be taken lest people having a small quantity of sugar present should be unduly alarmed. But, we are not prepared to accept the dictum of Kühne that 0.1 per cent., and of Roos that 0.3 per cent. may be possible under normal conditions, unless this amount be only temporarily present. The chemical studies of the urin show that the author is familiar with the subject, and exhibits careful scientific reasoning.

The chapter on Diabetes Infantilis is deserving of careful attention, as we are sure that this condition is at times overlooked in early childhood

We think it advisable that the urin of young children should be frequently examined, if there be the slightest suspicion of diabetes present.

Chapter VIII., on Investigation of a Case of Diabetes, should be studied carefully by every practitioner.

In Chapter IX., on Treatment, will be found much sound information, presented in a clear, concise manner.

On the whole, the work is admirable in conception and execution. It is the work of a practical physician, simply and lucidly written, and is a valuable addition to medical literature. It will take its place by the side of the magnificent works of Van Noorden and Neunyn. STORCK.

Stringtown on the Pike. A Tale of Northwestern Kentucky, by JOHN URI LLOYD. Dodd, Mead & Co., New York, 1900.

In his advice to a young student in science, one of the recent philosophers of Germany commended the acquirement of a knowledge of science first before attempting the unknown field of literary work. That Dr. Loyd has done this is evident in the book before us. The long practical life in a profession requiring research and acute detail is reflected in the study of life this novel presents. The breath of mysticism pervades and the air of pathos and science fill and conclude the book. The fetichism, voodooism, and supernatural in the old time negro life are depicted in a graphic way. In reading the fragmentary philosophy of the old Guinea slave, every Southern man who has lived over thirty years is sure to be filled with the memory of childhood when superstition and able advice fell from the lips of "Old Mammy."

Amid the simplest of country environs the author has related a story full of pictures, each of thrilling interest. With it all there is a thread of a love tale, the devotion of a slave, the argument of justice versus the law a strong description of the Kentucky feud, a sprinkling of war life in Kentucky, and here and there a study in local dialect, enhanced by negro folklore, which, together with the story, make a book full of incident, rich in climaxes and written with all the depth of feeling which only an intimate observation of the scenes could have inspired.

The publishers have presented the book in neat style and with delicate half-tone illustrations adequate to the text. DYER.

The Medical News Visting List for 1901. Lea Bros. & Co., Philadelphia and New York.

Besides its daily usefulness as a record book, this compendium contains a well selected collection of points of information, arranged for the busy physician.

Saunders' Pocket Medical Formulary. Sixth Edition. W. B. Saunders & Co., Philadelphia, 1900.

A multitude of suggestions for various conditions of diseases is embraced in a book of convenient size and shape. Blank pages are interleaved for additional formulæ or notes.

A Reference Hand-book of the Medical Sciences by various writers. Edited by ALBERT H. BUCK, M. D. Vol. I. Wm. Wood & Co., New York, 1900.

The first volume of this undertaking is notable for the comprehensiveness in the material and in the number of contributing writers, no less than 125 subscribing to the articles presented. The work is alphabetically arranged and in about 800 pages, a vast amount of matter is condensed, while the illustrations are ample and excellent. DYER.

A Pilgrimage, or the Sunshine and Shadows of the Physician. By WM. LANE LOWDER, B. S., M. D.

In a handy little volume Dr. Lowder has reprinted a series of essays, lectures, etc., delivered from time to time at medical meetings and such occasions. These articles reflect the broad philosphy of the author, dealing with the personal equation in the doctor's life. Stepping aside from the commercialism of it, he pictures ideals and from the novitiate to grey old age's cynic, the doctor passes through his hands. DYER.

The Physician's Visiting List for 1901. P. Blakiston's Sons & Co., Philadelphia.

This publication enters with the present issue the fiftieth year of its existence. It is presented in three editions, the *regular* or weekly, dated; the *perpetual*, same as last, but without dates; the *monthly*, not dated, but divided for monthly accounts.

The lists are neat, strong, and include nearly twenty pages of useful information, in addition to the space for records and book-keeping.

PUBLICATIONS RECEIVED.

Sexual Debility in Man, by F. R. Sturgis, M. D.—E. B. Treat & Company, New York, 1900.

Anomalies of Refraction and of the Muscles of the Eye, by Flavel B. Tiffany, M. D.—Hudson-Kimberly Publishing Co., Kansas City, Mo., 1900.

The Physician's Visiting List for 1901.—P. Blakiston's Son & Co., Philadelphia.

Transactions of the American Odontological Society, 1900.

Proceedings of the Philadelphia County Medical Society, October, 1900.

A Compend of Diseases of the Skin, by Jay F. Schamberg, M. D.—P. Blakiston's Son & Co., Philadelphia, 1900.

Progressive Medicine, Edited by Hobart Amory Hare, M. D. and H. R. M. Landis, M. D.—Lea Bros. & Co., Philadelphia and New York, 1900.

The Treatment of Fractures, by W. L. Estes, M. D.—International Journal of Surgery Co., New York, 1900.

Refraction and How to Refract, by James Thorington, M. D.—P. Blakiston's Son & Co., Philadelphia, 1900.

A Manual of Surgical Treatment, by W. Watson Cheyne, M. D. and F. F. Burghard, M. D.—Lea Bros. & Co., Philadelphia and New York, 1901.

Therapeutics: Its Principles and Practice, by Horatio C. Wood, M. D.—J. B. Lippincott Company, Philadelphia and London, 1900.

Obstetric Clinic, by Denslow Lewis, M. D.—E. H. Colegrove, Chicago, Ill.

Reprints.

A New Nasal Splint—Retinitis Albuminurica, with Report of Cases, by Francis W. Alter, M. D.

Impetigo Contagiosa Bullosa; Its Relation to Pemphigus Neonatorum, with the Bacteriology of Eight Cases, by Martin F. Engman, M. D.

Rœntgen Rays in the Treatment of Skin Diseases and for the Removal of Hair, by William Allen Pusey, M. D.

The Diagnosis of Hysteria, by Charles W. Burr, M. D.

Methods in the Diagnosis of Diseases of the Stomach, by Charles D. Aaron, M. D.

Iritis: Causation, Diagnosis, Prognosis and Treatment—Removal of the Cervical Sympathetic Ganglia for the Relief of Exophthalmic Goitre, with the Report of a Case—Report of Four Cases of Mastoid Abscess, by M. F. Coomes, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR NOVEMBER, 1900.

CAUSE.	White.....	Colored...	Total .....
Fever, Malarial (unclassified)	6	3	9
" " Intermittent	2	1	3
" " Remittent	2	2	4
" " Congestive	2	2	4
" " Typho	2	3	5
" Yellow			
" Typhoid or Enteric	4	1	5
" Puerperal			
Bronchitis	4	5	9
Cancer	15	7	22
Consumption	41	28	69
Diphtheria	3	1	4
Influenza	1		1
Measles			
Whooping Cough			
Pneumonia	19	17	36
Diarrhea (Enteritis)	13	4	17
Dysentery	1	5	6
Gastro-Enteritis	6	1	7
Hepatitis		3	3
Hepatic Cirrhosis	5	2	7
Peritonitis		4	4
Debility, General	1	1	2
" Senile	9	8	17
" Infantile	1	5	6
Bright's Disease (Nephritis)	33	16	49
Uremia			
Heart, Diseases of	29	25	54
Apoplexy	7	3	10
Congestion of Brain	5		5
Meningitis	11	1	12
Tetanus, Idiopathic			
" Traumatic	1	1	2
Trismus Nascentium	8	5	13
Injuries	12	6	18
Suicide	3	1	4
All Other Causes	96	38	134
TOTAL	342	199	541

Still-born Children—White, 19; colored, 11; total, 30.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 19.52; colored, 26.53; total, 21.64.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.14
Mean temperature	64.
Total precipitation, inches	1.29

Prevailing direction of wind, northeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. FEBRUARY, 1901. No. 8.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

ADDITIONAL NOTES ON THE NATURE AND TREATMENT OF LEPROSY.

BY R. H. L. BIBB, M. D.,

LATE PHYSICIAN AND SURGEON-IN-CHIEF TO THE AMERICAN HOSPITAL, CITY OF MEXICO, CHIEF SURGEON TO THE MEXICAN NATIONAL RAILWAY, ETC., SALTILLO, MEXICO.

In 1894[1] I published the photograph and the history of the original of the photographs accompanying this article. His history was as follows:

"The subject of Fig. No. 2, aged 22 years, a shepherd by occupation, is the only living child * * * she never had another living child * * * of a leper mother who died of puerperal fever at his birth. Her mother, a brother and two sisters were lepers. When she married, she moved to a distant place from where she was born, *to a locality where leprosy had never been known.* He was born four years after his mother's marriage; was raised on goat's milk; never saw a leper; never left the locality where he was born and raised until he did so to consult the writer; had lived since ten years of age, out of doors, herding goats, high up in the "Sierra Madre" mountains; was never vaccinated; never had syphilis nor skin eruptions, nor

1 *Amer. Jour. Med. Sciences*, November, 1894. The Alvarenga prize essay for 1892.

gonorrhea. His food for most part has been goat's milk and fresh eggs, beans, *tortillas*, coffee and dried fish occasionally. Nodules began on the ears and face at twenty, and gradually extended until they became plentiful on his hands, forearms, feet and legs, with now and then an ulcer."

His appearance, January, 1888, date of his first visit to me, is well shown in photograph No. 1, which was taken at that time.

The patient, more than ordinarily intelligent for a leper, says his mother died of *post partum hemorrhage* instead of puerperal fever as reported above, and that he never nursed nor had any connection, whatever, with her after birth—she dying a few hours after. His history was furnished by himself, and he has been at pains to elucidate it to the utmost. To this end he has visited, at my suggestion, the locality of his mother's nativity, and sought out his relatives from whom he learned that leprosy has been in the family as far back as their information extends —that the disease has clung to the family for ages. His father, aged sixty-eight, is in perfect health and informs him that the disease was not very far advanced in his mother at her death. She was but slightly disfigured by the tubercles on her face, ears, hands and feet. She was not ulcerated, and suffered mostly from neuralgic pains along the course of the principal nerve trunks. She also complained of areas of almost complete anesthesia in various portions of the upper and lower extremities, especially of the fingers and toes, which she would frequently burn unconsciously.

The patient states that, although his attention was first directed to the tubercles on his face at about twenty years of age, he had experienced, from childhood, shooting pains along the arms and legs, with numbness of the fingers and toes—as if asleep, and that though often severely pricked by thorns, the pricks never caused him pain; on the contrary, the sensation was more pleasant than otherwise, and that he would frequently find a thorn deeply imbedded in an arm or a leg without knowing it was there.

He denied that his sexual powers were deficient, and claimed that his testicles had never given any trouble. (In a sample of spermatic fluid he furnished me in January, 1888, I found abundance of live spermatoza). He married, at twenty-two, a healthy, vigorous woman of eighteen who bore him a daughter

the year following, another eighteen months afterwards; subsequently, two sons, all of them, apparently, sound and healthy; she has never aborted nor miscarried.

When first seen, he was put on chaulmoogra oil, and was urged to use it, externally and internally, as liberally as he possibly could, and to the exclusion of all other remedies. He began taking the oil in five drops doses, in capsules, *after meals*, swallowing it with a full glass of milk, and gradually pushed it, in four months, to three drachms daily—the largest quantity of the oil that any of my patients ever succeeded in taking in that



Fig. 1.

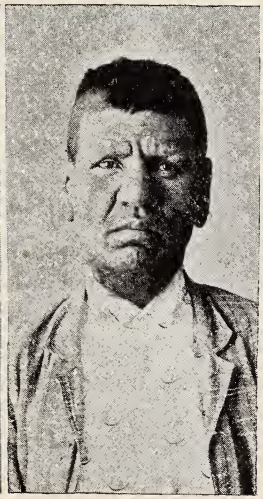


Fig. 2.

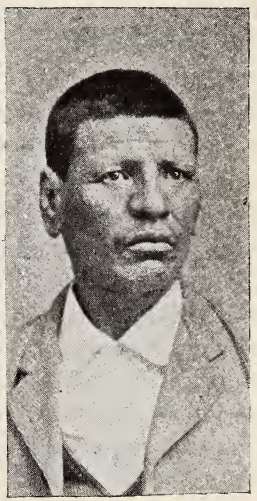


Fig. 3.

time, anointing himself, from head to foot, with two ounces of the remedy every third day, after a green soap and warm water bath, wearing his clothing until actually saturated with the oil before changing them.

In three months the patient reported that he felt better; that the fugitive, rheumatic pains were less excruciating; that the numbness of the fingers and toes, and the anesthetic spots about the arms and legs and body, were giving way to something like natural sensation; that the nodules were decreasing in size; the ulcers, abrasions and fissures were healing, and that the cutis was becoming soft, less ashen and smoother.

The treatment detailed above was continued, uninterruptedly, until January, 1892, when photograph No. 2 was made, which,

while it shows a remarkable change in the man's appearance, is far from showing the actual improvement in his condition. He has gained thirty-five pounds in flesh. (My observation, after extensive use of chaulmoogra oil in other diseases than leprosy, is that patients lose flesh rapidly under its use for some time after beginning to take it, and that the reduction is much more marked if the oil is used externally at the same time.) He eats, sleeps and works well; is free from pain and numbness; tubercles on the ears, face and hands greatly reduced in numbers and size, indeed, the smaller ones from the brows, the nose, ears and cheeks almost wholly gone, leaving one conspicuously prominent to the right of the median line, at the juncture of the mucus membrane and skin of the upper lip, more prominent even than in photograph No. 1. In short, the patient believes himself well and a leper no longer, and yet

> "He was in his lustie age,
> The lepre caught in his visage."

I had great difficulty in convincing the man that he was far from being cured and in convincing him of the vital importance, to himself and family, of further medication. I gave it as my opinion that lepers often failed of relief simply because they, as a class, were so wanting in perseverance that they could not be persuaded to carry out any line of treatment long enough to derive any permanent benefit from it. Finally, after showing him the photographs of many victims who had been almost distorted out of all human semblance by lepra mutilans, assuring him that such would be his fate unless he consented to continue treatment, and did so, as assiduously for the ensuing two years as he had from the beginning until now, by which time I would insure him to be well, he consented, provided himself with a large supply of the oil, in capsules and in bottles, and left for his home.

The patient did not consult me again until January 10 of last year, 1900, when he did so about the health of his wife, aged thirty, and his two daughters, aged, respectively, eleven and nine years—his two sons died of variola the year previous.

Aside from an extensive laceration of the cervix uteri, with its resultants, which I repaired, I found nothing ailing his wife. She has since become pregnant. The daughters are both

affected with "lepra mixta", of the maculo-anesthetic type, the first symptoms appearing three and four years ago—in the oldest child first. The children were placed on chaulmoogra oil, with directions to father and mother to observe, strictly, the method that has given such good results in the father's case. At last report they were both improving.

Photograph No. 3 shows the patient's condition, January 10, 1900, *twelve years after he began, and six years after he discontinued treatment.* While the patient is marvelously improved, perhaps practically cured, I do not believe he is *radically cured*, nor do I believe he will ever be, *not that the disease is incurable, but simply because he believes he is cured, but can not be induced to medicate himself further.* This has been the chief difficulty with *every leper* patient I have had to do with, even when medicines have been furnished them gratis—a big item in this country where drugs are from three to four hundred per cent. higher than in the United States and elsewhere.

My experience in the treatment of leprosy embraces more than a hundred cases. Most of my records have been destroyed, and I can not, therefore, give exact figures—and while I have never had results surpassing those obtained in this case—for, with one *single exception*, where they were equally marked, I have succeeded in inducing lepers to persist in treatment as this man did. I *have never failed to see benefit follow the use of chaulmoogra oil*—my experience is confined to the article furnished by Parke, Davis & Co.—if *used, for several months, as herein indicated*; and I begin to regard it as being to leprosy *almost* what mercury and iodide of potash is to syphilis.

I have, on a former occasion,[1] recorded *my* convictions—the most of them convictions, nothing more:

"That leprosy is a specific disease, due to the presence of the lepra bacilli. * * *

"That no one has succeeded in cultivating the baccillus of leprosy. * * *

"That experiments have not demonstrated leprosy to be inoculable on man or beast. * * *

"That leprosy is influenced by race, climate, soil, food, etc., only in so far as these environments tend to enervation on the one hand, or to physical well-being on the other. * * *

1. *Loc cit.*

"That leprosy is hereditary.

"That leprosy is contagious, infectious and communicable, under conditions not yet understood.

"That leprosy is both mitigable and curable.

"That chaulmoogra oil is a drug of unquestionable value in the treatment of leprosy.

"That leprosy may be completely eradicated from the list of human ills."

Time, additional study and a more extended acquaintance with leprosy, have all tended to strengthen these convictions; for since placing them on record—April 20, 1892—nothing has been said, nor written, nor done—no new discovery made—with which I am familiar, that adds much to, or that militates much, if any, against the accuracy of either, unless it be, *perhaps*, to lessen the probability "that leprosy is hereditary," which holds good, also, with its *congener*, tuberculosis. Lamentable to write, nevertheless true, nothing, absolutely nothing more is known of life history of the bacillus of leprosy to-day than was known then. It has not even been *proven to be the cause*, the *"primum mobile" of the disease*, *"and the inference that this bacillus bears an etiologic relation to the disease with which it is associated, is based entirely upon the demonstration of its constant presence in leprous tissues."*[1] Italics mine.

Prof. Dyer[2] of New Orleans, an *agnostic* as to hereditary leprosy, who believes leprosy to be incurable, "because no systematic attempt has ever been made to try to cure it," while reporting some encouraging results from injections of Calmette's antivenene, claims he has had more good results from thirty to sixty grains of chlorate of potassium given internally, daily, well diluted with water, than with any other drug. He regards leprosy as a preventable disease, and urges it upon the National Congress "as a vital and pregnant question to be discussed and disposed of before the need becomes a crying one, and before leprosy becomes so disseminated throughout the United States that a more than active effort will be required for its control and suppression."

The recent action of the authorities of one of the most populous and important cities in the American Union, if true as re-

1. Park's Bacteriology in Medicine and Surgery.
2. *St. Louis Cour. of Med.*, May, 1900.

ported, in turning a lot of lepers loose upon an innocent and unsuspecting people, in utter disregard of the warnings of the past and in violation of the often expressed convictions of countless able and conscientious medical men throughout the world, not only displays either an unpardonable want of knowledge of the dangers to which such action subjects their constituencies, or a woeful disregard of the welfare of the community they represent, whichever it may be and however astounding in this enlightened era, that can not be deplored in language sufficiently expressive, but also, the burning necessity for a department of the general government, *supreme in matters of like public import*, to obligate recalcitrant States and communities to take charge of, to restrain and to care for such cases, or do so itself, just as the U. S. Marine Hospital service would do now, should any State permit endemic cases of bubonic plague or small-pox, of cholera, of typhus or of yellow fever, however few of them, however remote the danger, to remain in its territory an unfettered menace to public health and prosperity; and yet, in the light of the history of the spread of the blight and of the devastation from leprosy in the middle ages, the consequences from the one could neither be more certain, more direful nor more lasting in the near, than they will surely be from the other in the more distant future, if cases of leprosy are permitted to come and go at will.

STRICT SEGREGATION IS THE REMEDY.

OPERATION FOR SEVERE PERINEO-SCROTAL HYPOSPADIAS.

[A supplement to the article on the Treatment of Hypospadias, published in the January issue of the JOURNAL].

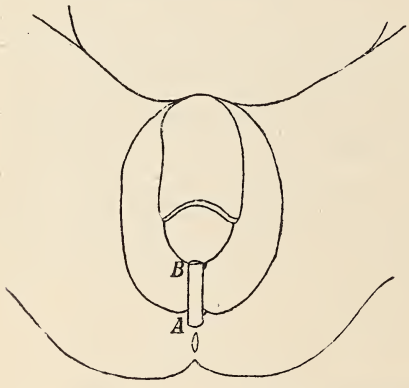
BY F. W. PARHAM, M. D., PROFESSOR OF GENERAL CLINICAL AND OPERATIVE SURGERY IN THE NEW ORLEANS POLYCLINIC, ETC., NEW ORLEANS, LA.

Since the publication of my article in the last issue of the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, I have read with much pleasure in the *British Medical Journal* of November 17, 1900, a paper by R. Hamilton Russell, of Melbourne, Australia, giving the details of an operation for severe hypospadias, devised by him, which seems to me well worth the consideration of the operative surgeon.

Figure 1 shows the organ in its state of deformity. The urethra opens at A, in the perineum, and the sulcus, lined with mucous membrane, extending from A to B, may be designated as the "perineal urethra." The penis is bound down to the scrotum, so that erection of the organ is impossible. There is no urethra in the penis, even the glans penis being imperforate. The objects of the operation are, of course, to straighten the penis and restore the urethral canal. These results, Russell, it will be seen, accomplishes in two operations:

First Operation.

Step I. A thread having been passed through the glans to serve as a tenaculum, an incision is made through the band which binds the organ to the scrotum. This incision may be



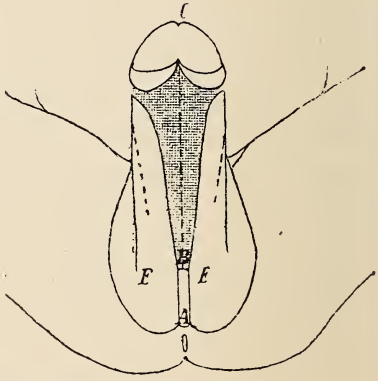


Fig. 1. [From British Medical Journal] Fig. 2.

carried at once around the penis, back of the corona but not too close to it. With the tip of the left index finger inserted into the gaping wound, the resisting structures are felt, and one by one divided until they have been sufficiently cut to allow the penis to be drawn out straight. Whatever be in the way must be cut. This part of the operation is conveniently done with scissors. There will now be left a great length of raw surface exposed. The median sulcus between the corpora cavernosa may be deepened by cutting away the remains of the fibrous bands that have been divided in the releasing operation. The shaded part in figure 2 shows the extent of raw surface exposed.

Step II. A channel is made through the glans by means of a

tenotomy knife introduced with the cutting edge turned towards the dorsum and close to the under surface; the edge is carried freely towards the dorsum, thus making a cut in only one plane.

Step III. The incision indicated by the dotted lines EE, Figs. 2 and 3, starting near the end of the perineal urethra, about one-third of an inch or less from the skin edge of the raw surface made by the straightening of the penis, is carried, always parallel to the skin margin, over the dorsum of the penis to the corresponding point on the opposite side of the end of the perineal urethra. A strip of prepuce will thus be marked out very closely resembling a clergyman's stole (see Figs. 2 and 3). This loop of skin is now dissected loose from its connections everywhere except at its extremities, and is then slipped over the glans exactly as the clergyman removes his stole. A sinus forceps is passed through the perforated glans, the loop caught up and pulled through in such manner as that the raw surfaces of the loop will be in contact with the raw surface of the slit in the glans. The loop is seen bulging in Fig. 4 on the sinus forceps. The redundant loop is cut away and a few stitches applied to hold the skin in place.

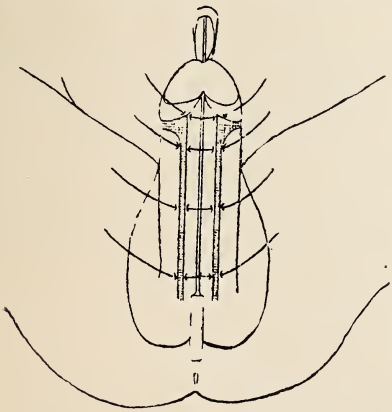


FIG. 4.



FIG. 3.

Step IV. Adjustment and suturing of the preputial flaps.

On the *dorsum* of the penis the procedure resembles closely the suturing of circumcision; on the under surface of the organ where the prepuce is made to cover over the two edges of the new urethra (Fig. 4), these edges should be included with the sutures, so that each suture should catch up and bring together four cutaneous edges, two of prepuce and two of new urethra. Before tying these sutures inspection should be made of the junction of the perineal and the new urethras; a nipple like projection at this point should be snipped off with the scissors. In putting these sutures through they should not take up the skin

edge itself but the raw surface underneath and between the edges so as, like fine Lembert sutures, to invert the edges of the new urethra. Figure 4 should show the strips of skin on edge and not as depicted. The deeper edges of these strips should be well adjusted in the sulcus between the corpora cavernosa but will not require any suturing. The result of the operation is shown in Fig. 5. No catheter or rod of any kind should be inserted into the canal. (What appears to be the handle of the staff in Figs. 4 and 5 is really intended to represent the perineal urethra, yet remaining to be closed.)

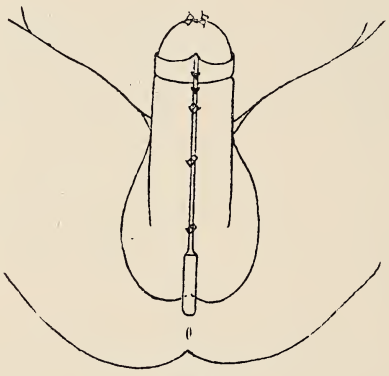


Fig. 5.

SECOND OPERATION.

SUPRAPUBIC CYSTOTOMY AND FORMATION OF THE PERINEAL URETHRA.—One point is of paramount importance: the ridge where the urethral mucous membrane merges with the skin of the perineum must be accurately defined and the separation between the two be made just along this line. It may be done by cutting off with a delicate pair of scissors the crest of the ridge all the way around. The skin of the perineum just behind the urethra had best be incised a little so as to expose well the posterior boundary of the urethra. The perineal skin along the urethral groove should de dissected up a bit so as easily to bring the two edges together to form the canal. A dressing of collodion is then applied. Healing *per primam* will make it right to take the suprapubic drain out in a fortnight. The description of the operation here given is practically that of Russell, only such modifications being made as we deemed likely to make it clearer.

I do not see the necessity of a suprapubic drain in the operation. A Watson's perineal tube inserted well back in the perineum would be much simpler and answer every purpose. The urethra could then be closed by the Duplay method. The whole procedure could be carried out satisfactorily in two stages. It is certainly an admirable operation and will save much time. It will be observed that Russell, also, utilizes the prepuce for lining the canal in the glands made by perforation as done in the operation of Weller van Hook. The manner of using it in Russell's procedure is very ingenious, taking, as he does, two straight flaps of prepuce to line the two walls of a *linear* slit in the glans. It seems to have another advantage, in that it disposes at once of the redundant prepuce, making the result strikingly like that of a very neatly done circumcision.

SPINAL ANALGESIA.*

BY DR. E. D. MARTIN, PROFESSOR OF MINOR AND CLINICAL SURGERY, NEW ORLEANS POLYCLINIC; VISITING SURGEON TO CHARITY HOSPITAL, ETC.

The best result is obtained by using a small amount of a strong solution.

To obtain analgesia by cocainization of the spinal cord, I believe we can always expect the most satisfactory results by injecting into the spinal canal the smallest quantity of fluid necessary to convey the requisite amount of cocain, thereby lessening the danger from sepsis and the disagreeable post operative symptoms due, possibly, to increased tension or to some other unknown cause of disturbance in the canal.

On November 9, 1900, I operated on my first case. The patient was a young colored woman with a deep fissure over the coxcygeal region. She was extremely sensitive and suffered acutely whenever the wound was dressed. As the urine contained hyalin and granular casts, I determined to operate under spinal anesthesia. I used 15 M of a 2 per cent. solution (gr. 3-10), anesthesia was complete in 14 minutes, and lasted 36 minutes. Two hours after the operation her temperature began to rise and the pulse to increase. At 7.30 P. M., nine hours

* Read at the meeting of Orleans Parish Medical Society, January 26, 1901.

after the operation, the temperature rose to 104 2-5, pulse 120, accompanied by nausea and vomiting and intense frontal headache. Symptoms subsided gradually, but lasted over a period of four days. From my observations of this case I felt convinced that these were not the symptoms of cocain poisoning, but were produced, I believe, by disturbance in the canal, possibly to the suddenly increased tension. I then determined that on my next case I should use a smaller quantity of a stronger solution and disturb the normal conditions of the spinal fluid, both as to distension and specific gravity, as little as possible, and so expressed myself to friends here and at Atlanta, at the meeting of the Southern Surgical and Gynecological Association. The results of these conclusions have thus far been more than gratifying, as the appended cases will show. With but two exceptions these patients were anesthetized in the recumbent position, the shoulders being elevated to curve the spine laterally. I found the interspace between the spinous processes of the fourth and fifth lumbar vertebra and kept the index finger of my left hand upon the spot. Just to the right side I injected a few minims of a schleich No. 1 solution; I then introduced the needle along the side of the finger pointing slightly inwards and upwards, and have found little difficulty in entering the canal. One to three minims of spinal fluid usually escaped before I attached the syringe loaded with the 10 to 15 minims of a 4 per cent. solution. I injected always 7 minims, allowing 2 minims to fill the calibre of the needle. It was then removed and the point of puncture sealed with collodion. The results are shown in the following cases which I have been able to gather, and for the compilation of which I am indebted to my assistant, Dr. Moss:

Case I.—Colored female, age 34, serpiginous chancroid, so extensive that the buttocks had been divided, exposing the coccyx and two inches of the rectum. General condition very bad. Temperature 101, pulse 130, urine contained albumin and casts. Injected 5 minims of 4 per cent. solution (cocain gr. 1-5), curetted and cauterized, operation painless, anesthesia complete in 10 minutes, lasted 1 hour and 20 minutes, absolutely no after symptoms. Patient continued to grow weaker and died on fourth day.

Case II.—Colored female, age 60. General condition bad.

Suffering from septic fever, result of traumatic gangrene of left leg extending to knee. Pulse 90 and small, temperature 100 deg.; used 5 minims of 4 per cent. solution (cocain gr. 1-5), complete anesthesia in 17 minutes, amputated at lower third of thigh, painless, condition slightly improved on evening of operation. *No after symptoms whatever.* Twenty-four hours after operation temperature rose to 101 4-5 and continued to fluctuate between 100 and 102 deg. Examination of stump showed that gangrene was extending. Condition remained practically unchanged until death occurred suddenly six days after operation, undoubtedly due to embolus.

CASE III.—Colored female, age 75. Gangrene of foot. General condition very bad. Anterior curvature of spine, injected 5 minims of 4 per cent. (cocain gr. 1.5), anesthesia complete in 14 minutes, operation painless, absolutely no after symptoms, not even elevation of temperature; died two weeks after operation from old age.

Three days before in this same case, I attempted to reach the canal between the fourth and fifth lumbar vertebra, but failed to get the fluid, for some unknown reason; it was this failure that caused me to inject higher.

Post mortem revealed marked anterior curvature of spine, with ankylosis, but canal normal. Dr. Laplace relates a similar experience with one of his cases.

CASE IV.—Colored female, age 25. Suppurative arthritis of knee. Temperature at time of operation 100, pulse 90. Injected 5 minims of 4 per cent. solution (cocain gr. 1-5). In 9 minutes anesthesia complete. Although the limb was so painful before injection that she could scarcely bear the weight of the hand upon it, under anesthesia she could use it freely, and manipulation was absolutely painless. Explored, found no pus, although two ounces had been withdrawn the day before. Knee bandaged and patient removed to ward. One hour later patient had a chill followed by elevation of temperature, nausea and vomiting; a second chill 6 hours after, temperature running up to 105 deg., pulse 135, but no nausea and no headache. Temperature next morning was 102 deg., but no other symptoms, temperature still continues, two weeks after operation, though quite low, ranging from 99 deg. to 101 deg. Was this due to sepsis from the joint, or to the lumbar puncture? If to

the latter, the symptoms subsided in a remarkably short space of time.

Case V.—Case of Dr. Dupaquier. White, male, age 50, stricture of urethra, general condition fair, heart weak, had taken chloroform for previous operation, but badly, and spinal anesthesia was decided upon. 5 *m.* of 2 per cent. solution (cocain gr. $\frac{1}{10}$) injected. Anesthesia complete in eight minutes. Has had absolutely no symptoms following.

Case VI.—Patient of Dr. Matas. Age about 50. Very nervous and anemic. Ulceration of rectum. Injected 5 *m.* of 2 per cent. solution (cocain gr. $\frac{1}{100}$). Anesthesia in six minutes. No after symptoms whatever in this case.

Case VII.—Patient of Dr. Souchon; age, about 50. Very anemic; both heart and kidneys seriously involved; gangrene of stump of amputation. Injected 5 *m.* of 4 per cent. solution (cocain gr. $\frac{1}{5}$). Anesthesia in 10 minutes. Amputated lower third of thigh. No after symptoms in this case.

Case VIII.—Colored female; age, 53. Condition, fair. At time of operation, pulse 110. Malignant tumor involving scarpal glands, suppurating at time of operation. Injected 2 *m.* of a 10 per cent. solution (cocaine gr. $\frac{1}{5}$). Operation painless, though sensitive to touch, heat or cold. Pulse after operation, 94. Now thirty-six hours after operation, and no after symptoms. All of these cases were in a very bad condition, and some of them would have met with immediate and certain death under general anesthesia.

From these reports it will be seen, that I have used from two to five *m.* of cocain in each operation. These cases are too few in number to establish any facts from which we can draw conclusions. I feel encouraged, however, in the belief that the theory, if not correct, is most rational, and I give it to the profession for what it is worth, hoping that it may prove as successful in other hands.

Notwithstanding these most gratifying results, a great improvement upon the same number of cases I have operated upon with a general anesthetic, I should hesitate in employing it in any case in which a general anesthetic could be given. In a very recent article, Dr. Maurice Richardson has called our attention to the mental condition of patients while undergoing operations, free of pain, 'tis true, but sensitive to every touch

and conscious of the terrible ordeal to which they were subjected. May not the mental shock resulting from such condition be far more serious than the risk of a general anesthetic? A patient said to me a few days ago, while his leg was being amputated, "I feel no pain, but am scared nearly to death."

It is in my opinion no longer an experiment. Its usefulness in certain cases has been demonstrated beyond any doubt, and patients who in the past, suffering with organic disease, who have been let to die knowing that a general anesthetic meant certain death, can now find relief, with every chance in their favor, through this wonderful medium, a discovery in my opinion second only to that of general anesthesia. It now becomes our duty to cautiously pursue our experiments in this line until a fairly certain degree of accuracy has been reached.

That we can ever reach a point of certainty in regard to the dose and amount to be injected is doubtful, for every temperament is different and danger frequently occurs when we least expect it. Is this not also true of general anesthesia?

The point at issue is, in what cases should we employ spinal anesthesia and which procedure will give the most satisfactory results. We should further bear in mind that no matter what the amount of fluid or strength of the solution employed, the danger of sepsis is always to be considered and the greatest precaution should always be observed in the preparation of the instrument and solution as well as the patient. It is certainly remarkable that a drug could act so positively in destroying pain, and yet not destroy sensation. Under its influence, patients feel and are sensitive to the changes of heat and cold.*

In conclusion I desire to thank Drs. Matas, Souchon and Dupaquier each for carrying out my suggestion in one of their cases, also others who have rendered valuable assistance.

[See discussion of this paper under heading Society Proceedings, this JOURNAL.]

* Has it not also opened up other great possibilities in the treatment of diseases where more direct applications can be made through the spinal fluid? In the light of my present experience I would favor the use of 5 m. of a 4 per cent. sol. for all operations on the extremities or pelvic organs and 5 m. of a 10 per cent. sol. on all operations about the rectum or genitals.

Clinical Report.

REPORT OF A CASE IN THE PRACTICE OF OBSTETRICS.

By DR. A. G. WILLE, M. D., Loreauville, La.

In the night of November 22, I was called about three miles in the country, to see a lady age thirty-two years, mother of five living children, this being her sixth pregnancy. On my arrival I took history and learned that hemorrhage had taken place after each of the last four confinements as soon as a child was born. I made examination and found os dilated only to the extent that I could insert index finger. I told the lady that everything seemed to be all right, as I had found head in L. O. A. position. Pains continued at long intervals until 3:30 o'clock when they became more regular and more force until 5:45 when child was born doubled upon itself. There was no amniotic fluid in front of head nor but little, about (8oz) after the birth of the child. About four mintes after child was born and had cried lustily, I cut the cord and gave the child in charge of a lady. I then tried to deliver placenta by Crede's method, but hemorrhage took place in about six minutes, and had to resist in order to stimulate by means of hypodermic of of strychnin nitrate $\frac{1}{50}$ gr. and nitroglycerin $\frac{1}{100}$ gr., also gave one drachm dose of normal liquid ergot and then continued my effort to deliver placenta, but after a while found placenta attached, and had to insert the whole hand in order to remove same, by peeling it from its attachment, but uterus still would not contract and hemorrhage continued. My patient's strength becoming less too fast, I injected again the same amount of strychnin nitrate and nitroglycerin and at the same time 15 minims of ergotole (S & D). Within six minutes had the pleasure of feeling the uterus contract and hemorrhage was stopped, then I irrigated the uterus with plain boiled water and my patient made good recovery with the exception of a little sore arm which got well, without abscess, however, and some after-pains which were treated with chloral and bromide mixture.

I am reporting this case, as it is the first encountered of the position of child and also to report the beautiful and most immediate effect of ergotole on the hemorrhage.

Charity Hospital Notes.

A CASE OF ACUTE LOBAR PNEUMONIA.

EPITOME OF LECTURE TAKEN FROM MEDICAL CLINIC OF DR. JNO. B. ELLIOTT PROFESSOR ON GENERAL AND CLINICAL MEDICINE, MEDICAL DEPARTMENT TULANE UNIVERSITY, NEW ORLEANS.

The patient is a white man, age 22, a native of New Orleans, ice man by occupation. He gives the history of having had malaria, but no syphilis. He is not an alcoholic. He was admitted to the hospital on December 4, having had a chill the night previous; pain in the side. Physical examination revealed dullness over the right apex, bronchial breathing, increased vocal fremitus. He has the characteristic flush of the cheek; which as a rule is most marked on the side of the affected lung. His pulse and respiration are rapid; the characteristic cough is also present, which is of a hacking nature, and the patient tries to restrain the act, especially where there is pleuritis. A diagnosis of acute lobar pneumonia, involving the right apex, has been made. Incidentally it may be remarked that in apex pneumonia the brain symptoms are intensified. Croupous or lobar pneumonia, as you are doubtless aware, involves a whole lobe, and has its origin in the air vesicles; while broncho-pneumonia as a rule involves isolated lobules, occurs more frequently in children, begins in the smallest bronchial tubes, and is bilateral. The latter affection is most frequently found in children complicating or following scarlet fever, measles, etc. It is also called lobular pneumonia. A clear distinction should be made between broncho-pneumonia and capillary bronchitis, which is a different disease. The pathogenic germ of lobar pneumonia is the diplococcus pneumoniæ. This micro-organism is readily demonstrated in the excretions of the mouth and throat in perfectly healthy individuals, and it is therefore with us always. It is then evident that the patient must under certain circumstances offer the conditions favoring or permitting of its producing its specific disease, lobar pneumonia. Such a condition is quite probably a diminished tissue resistance. Therefore the pneumococcus may be regarded as only one of the factors in the etiology. The different stages

of the pathologic changes you are all familiar with. The most frequent seat of the lesion is the base of the right lung. We presume that the right lung is attacked most frequently because it is larger and likely less resistant; the base suffers because it is most dependent and consequently also less resistant. No other disease except malaria is so constantly ushered in by a chill. It is an interesting observation that the chill of malaria almost invariably occurs in the day time, while that of pneumonia most frequently comes at night. The toxins of the pneumococcus strike directly at the nervous centers; the vasomotor center goes down, and we have a chill. This center then recovers its equilibrium, but the fever persists. With the temperature we have quick pulse and rapid respiration. The increased respiratory rate may be in part attributed to the vicarious effort of the organism and sudden diminution of respiratory area; but that the nervous system, affected by the toxins, is also at fault is evidenced by the fact that the rate of breathing becomes slower and approaches normal some time before resolution of the lung has begun. How would we distinguish between pneumonic consolidation of the lung and a condition presenting a thickened pleura? Both give dullness on percussion. But upon auscultation we would, in the pneumonic case, detect increased vocal resonance, bronchial breathing, brochophony, tactile fremitus increased, and probably a hyperresonant note over the unaffected portion of the lung due to the fact that this area is doing more work. In the case of thickened pleura none of these latter signs are present; but on the other hand we would probably find decreased voice sounds, decreased fremitus and the normal vesicular murmur diminished. In the case of a pleuro-pneumonia the solid lung signs would override those due to the thickened pleura; but with the intensity of the former much diminished. The physical signs of pneumonia may at the beginning be absent, or the pneumonic lesion may be deeply seated. In either instance we have only to wait. Ordinarily the first stage lasts a few hours, but its length depends much upon the patient. Crepitant râles may be heard in the early part of the first stage. If this stage is prolonged the other stages will be prolonged, and we will have delayed resolution. The first passes gradually into the second. The second stage may last from two to three weeks.

In the healthy, sthenic patient we may expect this stage and that of resolution to be rapid; in the strumous diathesis slow; in the gouty quick; in the syphilitic slow; in the scorbutic cachexia slow. Note the influence of diatheses and cachexiæ. The temperature record generally starts at about 103 deg. in morning, 104 deg. in the evening; running a regular remittent course for 5, 6 or 7 days. The higher the temperature, other things considered, the less favorable the prognosis. A low temperature in an asthenic case is a bad omen. Usually about the seventh day the nervous system recovers and we have the crisis.

TREATMENT.—Theoretically the treatment should be directed toward lowering temperature and supporting the heart. The right heart is more severely taxed in its efforts to drive the blood through the consolidated lung. The heart, however, usually needs no (special) stimulant, if we watch the temperature and do not allow it to climb too high. High temperature damages the heart. Cold applications are the best means of combating the temperature. In carrying out this measure the ice bag may be applied directly over the involved lung area; or in the less urgent cases, a cloth wrung out of cold water and so applied answers admirably. These applications to subserve their purpose must be constant and not intermittent. The use of cold in the treatment of pneumonic fever would doubtless be more extensively practiced were it not for the popular prejudice of the laity against the measure. Returning to the heart: as long as the pulse rate remains below 110 this organ is safe and able to take care of itself. If it shows signs of failure first try nourishing the patient freely and at short intervals; if this does not suffice give alcohol or strophanthus. Ammonium carbonate is an excellent stimulant in these cases; it is a heart stimulant, it alkalinizes the blood, is excreted by the bronchial mucus membrane and hastens resolution. It may be given in 5 gr. doses every three hours. If the rapidity of the heart's action increases push the heart stimulants. Strychnin should be given from the beginning of the attack.

N. O. Medical and Surgical Journal.

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE STATE SOCIETY MEETING.

Organization in the preservation of any community body is essential and in none more than with medical men. The profession in Louisiana has gradually increased to a very gratifying number of which only a fraction have linked themselves with the representative body.

In April, the 18th, 19th and 20th, the Louisiana State Medical Society will hold its twenty-second meeting, and this should be a banner year.

The last meeting was an unqualified success and the next one should surpass it. After all the question of two or three days in a whole year is a small consideration beside the benefit accruing from contact with fellow-men in the profession.

The life of the medical man is full of routine, and a short period of variety offers the inducement, while the usual knowledge acquired is additional reason for attendance.

Our country members are slow to get enthusiastic over a meeting of the Society, and it is now to them the appeal is specially made that they attend this year.

The program promises to be full of interest and it needs only a full membership in attendance to make the Society a credit to itself.

Every year it is more and more evident that medicine and surgery are advancing with a pace so rapid that the busy practitioner finds time only to watch the advance without sharing it. It is almost necessary to alter this; that occasional contact with those in the procession, and in front, should be sought after.

The published transactions of our State Society for several years show plainly that our State profession is intellectual and ready to learn, for the discussions are liberal and full of substance.

It is indeed little to demand of a member when he is urged to attend the meeting of a society for which he is as responsible as any other member, and in which his pride and support should be second to none.

As the official organ of the Louisiana State Medical Society, the JOURNAL feels warranted in its expressions of view, and whatever may be presented in these pages regarding the Society, may ever be looked upon as contributory to the advancement of the medical profession, and especially that part of it which Louisiana harbors.

UPHOLD A HIGH ETHIC STANDARD IN MEDICAL JOURNALS.

The editorship of the *Philadelphia Medical Journal* has been wrested from Dr. Gould, notwithstandiug his protest and, apparently, some at least implied vested rights on his part. The journal in question evidently cut out what was intended as Dr. Gould's farewell editorial utterance, thereby mutilating their table of contents, in their last number for 1900; published a salutatory in their number of January 5, without even mentioning Dr. Gould's name; and, finally, noticed on January 19, "Dr. Gould's retirement" by publishing a resolution of its stockholders placing on record their sense of deep appreciation and their thanks for "the energy and enterprise displayed by the late editor."

Were this only a personal or business controversy between Dr. Gould and the *Philadelphia Medical Journal* it would be barely necessary for us to mention the incident. However, questions so much more serious seem to be involved that we feel it our duty to comment in no uncertain terms upon what appears to be the reason for the change. Dr. Gould is *facile princeps* in medical editorial work, and the resolutions just referred to speak so favorably of him that, while on their face they are a hollow mockery, they aid in forming the conviction that a very serious purpose must have been back of the change made by the management. It can be inferred, from Dr. Gould's charges and other sources, that the *P. M. J.* has not made money for its stockholders and that the changes, which include its control by lay capital, are intended to accomplish more in a financial and com-

mercial way. The fear is engendered that the *P. M. J.* may not keep up its high ethic standard in the advertising department. We do not believe that a medical weekly spending enough on its scientific reading matter can make a profit, with the present prices of paper and printing, when charging only $3.00 per annum, even though it be blessed with a very large subscription list. Hence the temptation to swell the advertisement department is created. The greater the necessity, therefore, for a strict supervision of the same by a determined editor upholding and upheld by high ethic principles. We all know that Dr. Gould has been strict on this subject and, weighing all these circumstances, the question can not but obtrude itself—is that strictness the reason for the change?

Time will tell. We shall not be pessimistic on the subject, but will watch the future course of the *P. M. J.* with interest. Its management will pardon us if we utter a warning as we remind them of a prophesy made early in the career of the *P. M. J.* While protesting against the cutting of the subscription price below that of other high-class weekly medical journals, we expressed the opinion that such a course was unwise financially. Its status to-day shows that we were not far wrong, although able editorship and other good qualities have given it a weighty and admitted influence. We warn the new management that, unless they are particularly careful in their acceptance and rejection of advertisements, they will quickly lose for the *Journal* its standing and influence even though the change in policy succeed in increasing the surplus in their coffers.

Dr. Gould announces a scheme for the organization and capitalization of a new medical journal. We wish him the success that he deserves as an able and fearless medical writer; but while we have nothing to do with the business part of the undertaking, we dislike and regret his intention to fix his subscription rate at $4 per annum, as that is still a cut under the standard price. We believe that success is possible even though a dignified rate of compensation is asked of subscribers. The doctor's ability and energy, together with the active sympathy of the medical profession which is sure to go out to him, would combine to make his journal obtain a fair price and make him all the more easily independent of commercial influence. Five dollars is a small enough sum to pay a year for a good weekly medical journal.

As we are only one unit (though double) in a long line, many of whom have editorially gone before, and several of whom have also gone to their long reward, we may be pardoned for holding up this JOURNAL as an example, illustrating that a medical publication can insist on fair compensation from its readers, can be guided by high and ethic principles, and still survive, aye even profit. This JOURNAL charges $2 per annum, although many monthlies have cut the price in half; it systematically and persistently rejects any advertisement having the least objectionable feature from the standpoint of medical ethics, yet it can look back upon an existence of more than half a century and, at least under the present management, has declared a satisfactory dividend annually to its *exclusively medical stockholders.* Surely an ably edited and enterprising weekly published in a larger center should be able to succeed in proportion.

We take occasion to congratulate our colleagues of the weekly journals that upheld their prices and say to Dr. Gould: "Go thou and do likewise."

Society Proceedings.

TRANSACTIONS ORLEANS PARISH MEDICAL SOCIETY.

MEETINGS OF JANUARY 14 AND 26, 1901.

THE ORLEANS PARISH MEDICAL SOCIETY held its meeting for the inauguration of officers on January 12. The meeting was well attended and proved interesting.

DR. T. S. DABNEY, the retiring president, read the following address:

Gentlemen of the Orleans Parish Medical Society:

"It is meet and proper on this occasion that your president, before turning over the gavel to his successor, briefly call your attention to the work of the Society during the past twelve months. Upon taking the chair it was my fervent wish to see during my term the names of every qualified practitioner in the regular profession in this city upon our roll. Thanks to the zeal of some of our members, notably that of two of the young-

est, this wish has been largely fulfilled, as we now have one hundred and ninety-six names on the rolls and four on the blackboard. A year ago we had but one hundred and seventy-four. Like my five immediate predecessors, I voiced the wish that we might see our way, during my administration, to move into our own domicile. In this we have been sadly disappointed, the question of finance proving an insuperable obstacle; yet I earnestly urge you not to give up the fight, but to strive in every way possible to aid my successor, whose heart and soul is enlisted in this cause.

"I earnestly urge that immediate steps be taken to induce every member of the profession to subscribe an annual amount, say ten dollars for a period of five years, which amount is to be paid in four equal payments of two dollars and a half each, yearly. I feel sure the great majority of us would cheerfully deny ourselves some luxuries to acquire a home of our own, whilst some of the wealthiest in our ranks might be induced to make a handsome donation in so worthy a cause. I can not look with favor upon increasing the dues, as that, in my opinion, would prove too heavy a burden to some of our most deserving members; but a modest initiation fee, say one of $5.00, to be used exclusively for the acquisition of a domicile, might be exacted of all gentlemen seeking the distinction and profit of membership in our Society hereafter. During the term of the administration now drawing to a close the Society voted to issue a monthly bulletin; yet from a number of causes this has not been done. I trust that the incoming administration will see that this bulletin is promptly issued. Eighteen original papers have been read, many interesting cases reported, a number of very valuable pathological specimens shown, investigations into and reports on society practice, hospital abuse, during the past year. Hence it will be seen that the Orleans Parish Medical Society has been keenly alive to the medical questions of the day. I can not refrain from reminding you gentlemen that very many of you do not seem to realize the immense value of our library, with its numerous works of reference, its valuable reports from the Army, Navy and Marine Hospital Service, as well as the mines of wealth contained in the hundred and odd journals that we receive monthly.

"None of you have failed to notice the growing influence of

this Society in this city. The Orleans Parish Medical Society is now a well recognized factor in this community. And why? Because we have united the profession. It is no longer considered smart to deride us by calling our Society a little coterie or a self-adulation society. Our oldest and youngest members rub elbows together, discuss scientific questions together and break bread together every trimestre. Day by day we are getting better and better acquainted with each other, and our mutual esteem has been markedly increased. No longer does Canal street or the river divide us; we are now united and cemented by bonds of respect and esteen. Permit me, gentlemen, to thank you for the uniform courtesy shown me by all of you during my term of office, and to bespeak similar treatment at your hands for my successor."

The secretary's report and the treasurer's report were read, showing the society in an active condition.

The librarian, Dr. S. P. Delaup, reported the addition of 269 bound volumes, together with numerous pamphlets, unbound volumes, etc. Attention was directed to the valuable exchange list of THE NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, on file at the library, and the addition of some leading journals.

The Committee on Scientific Essays reported upon its work, and suggested methods of improvement in the detail of the arrangement of future work.

DR. E. D. MARTIN, the incoming president, delivered the following address:

Gentlemen of the Orleans Parish Medical Society:

"When you did me the honor to elect me president of this Society, I felt that its way had already been paved to an assured and successful career by my predecessors, and that I would have only to follow the beaten path, to reap the fruits of their labor. On reflection I am inclined to believe otherwise. Though the Society has been safely piloted across the sea of adversity, much yet remains to be done, and to accomplish which I shall depend upon and expect your hearty co-operation. There are two things we should to-night pledge ourselves to do, and do them we must, if we desire to raise the Society to its proper standard.

"Just nine years ago we moved into these quarters, then amply sufficient for our purpose. Look to-night at these crowded

shelves; if, because they are now filled, we are to stop our subscriptions, we had best disorganize the Society, for as such it has served its purpose. Look at the small seating capacity of these rooms, only one-fourth the number of chairs the roll of membership requires. If this condition is longer to exist, then, gentlemen, I say there is something radically wrong. Why are the 196 members of this Society paying dues regularly and not attending meetings? Is it from a philanthropic standpoint? No, it is because they know that such an organization is essential to the welfare of the medical profession and that the good work done by this Society must reflect credit on all its members; therefore, they are willing to back their convictions, not as they should, by an active interest in all medical matters, but by a paltry sum paid into the treasury of the Society. I say to you, the active members of the Orleans Parish Society, that these drones are reaping the benefit of your labors, and it is your duty to see that they mend their ways in the future. However, their friendly disposition towards the Society shows at least an interest in its welfare, but the time has come when they must be tested farther. To those of you who attend the meetings, I need not describe our present conditions, nor the absolute necessity of securing new quarters. The subject is not a new one, for several years it has frequently been dwelt upon, and at length, by your chief executives. The time seemed not yet ripe for acting. Now I believe it is, and I appeal to you in the name of the medical profession of New Orleans to loosen your purse strings and to come to its aid. With the proper spirit prevailing the task will be an easy one. Let us resolve to-night to lay the foundation of what, ere many months, will be the permanent home of this Society, fully equipped and with full capacity to properly conduct all scientific matters which must prove beneficial to ourselves and a credit to our profession. This done, we will have accomplished a great work.

"Again, I feel I must call your attention to another matter of equal importance. In glancing over our reports I am satisfied they are not what they should be, and I believe it is because we have grown into the careless habit of not reporting our cases and not taking proper interest in these meetings. The proceedings of this Society should rank with any in the country. We have the material at hand and the ability to utilize it, but I fear

we lack the energy to handle it. Gentlemen, let us arouse ourselves from the state of lethargy into which we have lapsed, and with the dawn of this new century make one more good resolution, which I need not word for you.

"It is the purpose of this administration to make an unusual effort to interest you all in the Society matters. We ask you to come to our assistance, and we feel that if we can only incite in you the proper professional spirit, the first year of the twentieth century will mark a new era in the annals of our local profession. We shall serve you as best we know, and for my part, if I err, you can attribute the fault to an error of judgment, not of heart."

The other new officers were installed, and the president announced the committees for 1901, of which the following are chairmen: Committee on Scientific Essays, Dr. E. H. Walet; Judiciary Committee, Dr. E. J. Graner; Committee on State Medicine and Legislation, Dr. A. G. Friedrichs; Conference Committee, Dr. F. W. Parham; Library Committee, Dr. J. A. Storck; Publication Committee, Dr. Isadore Dyer. Sub-committees were appointed on the reports of the retiring officers.

A resolution was passed unanimously to the effect that no papers shall be entertained by the Society unless a copy of the paper be delivered to the secretary at the time of reading, and that the secretary shall retain the same until delivered to the Publication Committee.

Refreshments followed.

Meeting of January 26, 1901.

Dr. E. D. Martin read a paper on *Spinal Analgesia* (see page 453, this Journal.)

Discussion:

Dr. Parham considered Dr. Martin's experiments valuable, and comparing results in other cases to those reported by Dr. Martin, agreed that solutions too weak should not be used. Since September, 1900, Dr. Parham and Dr. Perkins had used spinal injection of cocain on 15 cases. Without delaying to describe each case in detail, he called attention to some of the important facts and conclusions.

The first case was peculiarly suited to the method, as the patient was an old man, so debilitated by a long standing and extensive lumbar abcess that death seemed inevitable should a

general anesthetic be used. In two injections 77-100 of a grain was used. Analgesia as high as the tenth rib was complete in 22 minutes. After extensive incision, and curetting in the lumbar and iliac regions, the patient left the table smiling, and in as good a condition as when the operation was begun. Later, the suppuration continuing, another operation, fully as extensive as the first, was done under spinal injection with equally satisfactory result. In another case, a patient who complained of great pain on defecation, and who was very nervous and apprehensive, submitted to a thorough examination of the rectum without complaint, save that his legs were tired from being held by the straps.

Another young man who had repeatedly complained of such pain on the introduction of a speculum that office examination had proven impossible, submitted to dilatation and division of the anal sphincter without complaint.

In a recent case, a herniotomy, a general anesthetic was made necessary by the patient's physical condition. Although the assistants after testing with needles announced that analgesia was complete, the patient complained of great pain at the first incision. It was noticed, however, that a very small amount of chloroform sufficed. Dr. Parham believed that there had been sufficient anesthesia in this case from the injection, but that the patient had been aroused by his hearing "the knife" asked for. The method is not adapted to hysteric patients or children. Of his fifteen cases four were not followed by any untoward symptoms, and in none was there at any time any alarming symptoms.

Dr. Parham referred to Dr. Murphy's report of 592 cases, with five deaths, and Tuffier's series of 252 cases with five deaths. In Tuffier's cases four of the deaths were found to be due to causes other than the injection, and even the fifth could not positively be referred to that cause, as valvular disease of the heart was found at autopsy. Dr. Parham called attention to the difficulty of correctly measuring so small as two minims with syringes in ordinary use, and to the danger therefore of injecting too much or too little when using solutions so strong as 10 per cent. In his own series of fifteen cases Dr. Parham had found 2 per cent. to be most satisfactory. Also called attention to the fact that Tuffier, after such a long series of cases, clings to 2 per cent. There is a diversity of opinion as to the causes

of unfavorable symptoms following intraspinal injection. It is possible that intraspinal tension is actually diminished by the introduction of cocain solution, as we don't know what absorptive process may be caused by the changed chemical conditions. Weak solutions, being more slowly absorbed, may be expected to cause slighter systemic effects. Fowler found no difference in untoward results between injections of ¼ gr. and ½ gr. Dr. Parham insisted that a number of facts would have to be considered, such as amount of cocain, tension of spinal fluid before injection, etc.

Dr. Souchon corroborated Dr. Martin's statements concerning the two cases they had observed together, one of which was his own. He referred to the mental condition of the patient who is often hysterical and deceives the operator as to the results of the injection. The patient hears the remarks of the operator and is apprehensive of every touch. He advised either silence or the use of such terms as the patient does not understand. He thought further experiments would demonstrate the usefulness of spinal analgesia even where there is no contraindication to general anesthesia. As yet we are unable to tell the comparative danger of the two methods. One source of danger in the new method is lumbar puncture, which in itself has been known to cause death. However, the cause of death is uncertain. He asked whether injection in the cervical region, especially above the origin of the phrenic nerve, had been practiced, and if so what were the effects upon the heart and respiration? Injection in this region would also likely produce anesthesia of the upper extremities.

Dr. Parham, in answer, stated that injections had been reported between the sixth and seventh vertebræ, and the results found to be neither more extensive nor more satisfactory. Danger of wounding the cord must condemn this method.

Dr. S. P. Delaup: My experience with spinal cocain analgesia is limited to nine cases that I personally injected, and also to three other cases in which I assisted Dr. Gelpi. More than half of these cases were operated on in the clinic by Dr. Chassaignac before his Polyclinic class. They are as follows:

Case I.—Negro, 50 years old; operation, internal hemorrhoids; had nephritis; injected 2 per cent. cocain; 12 m.; analgesia in 9 min., lasted 35 m., extended to nipples; after effects, headache, fever 101 deg. F. lasting 12 hours. Result excellent.

Case II.—Date November, 1900; negro, age 20; case of fistula in ano, no organic disease; injected 8th, 2 per cent. cocain; analgesia in 7 min., lasted 60 min., extended to scalp; no after effects whatever. Result excellent.

Case III.—Date November, 1900; age 45; tuberculous ostitis of tarsal bones, injected 8 *m.* of 2 per cent. cocain), no analgesia followed, second puncture twenty minutes later, using 15 *m.*, partial analgesia fifteen minutes afterward, after effects slight headache, lasting ten hours, had nephritis, result fair, partial analgesia only, but operation practically painless.

Case IV.—Date December, 1900; mulatto, age 35; fistula in ano, condition had nephritis, injected 14 *m.* of 2 per cent. cocain, analgesia in seven minutes, lasted one hour and forty minutes, extended to mammary line, after effects, headache, nausea, vomiting, fever, duration of symptoms twelve hours, result excellent.

Case V.—Date December 20, 1900; negro, age 36; urethral stricture and fistula, performed external urethrotomy, had nephritis and cystitis; injected 10 *m.* of 2 per cent. cocain, analgesia in six minutes, lasted one hour and twenty minutes, extended to mammary line, after effects, slight headache, lasting ten hours, result excellent. This case was subjected to a severe and prolonged operation lasting over one hour. He stood the operation very well; at no time did he complain of pain, nor did he give any evidence of shock or depression. I consider this case as one of the most successful of my cases.

Case VI.—Date January 8, 1901; age 25. External hemorrhoids and rectal polypus, relieved by actual cautery; had nephritis, injected 10 *m.* of 2 per cent. cocain; analgesia commenced in 10 minutes, lasted 40 minutes and extended to mammary line, no after effects whatever. Result excellent.

Case VII.—Date January 15, 1901; negro, age 26 years, operation, fistula in ano; no organic lesion, weak and anemic; injected 10 *m.* of 2 per cent. cocain; analgesia began in 10 minutes, with no after effects. Result excellent.

Case VIII.—Date January 15, 1901; negress, 35 years old; hemorrhoids by cautery method; owing to nephritis used spinal anesthesia; injected 8 *m.* of 2 per cent. cocain; analgesia in 12 minutes extending to mammary line; the after effects in this case were the severest experienced by any of my cases. Three

minutes after the injection she was taken with nausea and vomiting followed by a cold sweat and marked depression. The vomiting soon ceased, but was followed by a chill and fever, 101 deg. F., the latter lasting about 12 hours. Result good

Case IX.—Date January 22, 1901; negro, age 25, with traumatic gangrene of big toe amputation; has nephritis and endocarditis; injected 10 *m.* of 2 per cent. cocain; analgesia began in 10 min., lasted 45 min., and exteded to mammary line; after effects—nausea, vomiting, headache two hours after operation, lasting twelve hours. Result excellent.

In the three cases that I assisted Dr. Gelpi, one was a complete success, the other two were only partial.

The first case, fistula in ano, in a negro, age 45; cavity at apex of the right lung. Ten *m.* of a 2 per cent. cocain solution was used. Analgesia in about ten min., lasted one hour, and extended to mammary line; operation lasted 15 min. The patient complained of slight nausea only.

The second case, a negro, age 30, with rectal ulcer.

Ten *m.* of a 2 per cent. cocain solution used. Patient complained of slight pain. Being removed, acknowledged that fear had actuated him in his complaint.

The third case was one of urethral stricture. Internal urethrotomy performed by the aid of spinal analgesia. The usual ten *m.* of the 2 per cent. cocain solution were injected.

In support of Dr. Martin's pressure or tension theory, in which I am inclined by recent observations to share, though not to the same degree, permit me to quote the opinion of a noted physiologist, and also to offer an abstract of Tuffier's recent report:

Flint says: "As far as we know, the functions of the cerebro-spinal fluid is simply mechanical, and its properties and composition have no very definite physiological significance. Its quantity was estimated by Magendie in the human subject at about two fluid ounces. The quantity obtained by Magendie probably does not represent the entire amount of liquid contained in the ventricles and in the sub-arachnoid space, but it is the most definite estimate that has been given."

Flint further says, the discharge of a certain quantity of the cerebro-spinal fluid does not produce any marked derangement in the action of the nervous system. When the liquid is

allowed to flow spontaneously through a small trocar, there follows no serious nervous disturbance, but, when the liquid is drawn out forcibly with a syringe, the animal first becomes enfeebled and afterwards seems affected with general paralysis. These phenomena are probably due, not so much to removal of the fluid, as to congestion of blood vessels and even effusion of blood, which follow sudden diminution in the pressure. Sudden increase in the quantity of liquid surrounding the cerebro-spinal axis produces coma, probably from compression of the centres. This fact was demonstrated by Magendie by injecting water in animals, and also by compressing the tumor in cases of spinal bifida in the human subject, by which the fluid was pressed back into the spinal canal. In the cases of spinal bifida, the subject, during the compression, fell into a coma, which was instantly relieved by removing the pressure. The cerebro-spinal fluid is speedily reproduced after the evacuation. In all probability it is secreted by the pia mater.

Abstract from Tuffier's article in the *Semaine Médicale* of December 12, 1900:

Spinal cocain analgesia. An experience of thirteen months with this method of analgesia, which Tuffier has applied in 252 operations, has established that there are no symptoms of shock, and that the patients return more rapidly to the physiologic condition than after general anesthesia. In 20 per cent. of his cases the analgesia proceeded without the slightest subjective or objective symptoms. In 40 per cent. nausea occurred, and he has remarked that this is most liable to happen in cases with slight tension of the cerebro-spinal fluid. When the fluid escapes like an ejaculation, there is a minimum of incidents, but when it trickles, the analgesia will be as complete, but is liable to be accompanied by some annoyances. Nausea is much more frequent after large doses. A general slight malaise is sometimes observed, commencing about five minutes after the injection, and never lasting more than fifteen minutes. Vomiting occurs from five to fifteen minutes after injection in 20 per cent.

He now rejects all substitutes for cocain. The brain is not affected and the muscles are completely relaxed, as in chloroform auesthesia. The rhythm of the heart is not altered, but the pulsations sometimes become more frequent. In 30 patients the

pulse was 80 at the close of the operation, and it has been known to reach 120. In 5 per cent. of his cases there was incontinence of gases or fecal matter. Tuffier has observed headache in 40 per cent. of his patients. It resembles migrain in character, and in 90 per cent. was almost completely gone by the next morning. No remedy seems to control it, and he now merely applies a compress of cold water to the brow. It is difficult to understand this cephalalgia, as the cocain disappears so rapidly from the cerebro-spinal fluid that not a trace can be discovered an hour after the operation. The temperature rose in 45 per cent. to 37.8, 38 and 39.5, and exceptionally to 39 and 39.5 centigrade. It commenced about four to six hours after the analgesia and never persisted beyond the twentieth hour. The elevation of temperature is probably due to the action of the cocain on the thermogenic centers.

In conclusion, I am of the opinion that analgesia by the new method of spinal injection is still in its experimental stage. Time and observation will alone clear the many mooted questions now at issue. So far as my observations have enabled me to judge I think the new method has come to stay, though not to supplant the general anesthesia. It has its limitations and its dangers, yet unknown. Let us then not be carried too far by our enthusiasm to abandon an old and tried method for a new and untried one. In future I shall use 5 *m.* of a 4 per cent. solution of cocain.

Dr. Gessner stated that his experience with spinal injection was limited. However, he had had one case with considerable after effects, which did not impress him as due to the cocain itself, as they did not correspond to such observed from local injection elsewhere. He thought we could already replace general anesthesia to a certain extent with it. At least, if he were the patient he would prefer the spinal injection, other things being equal. In regard to the psychic effects, he thought this could be remedied by giving the patient a few whiffs of chloroform immediately before the initial incision. He had noticed that some regions are affected more readily than others, *e. g.*, the perinneum, rectum and genitals are anesthetized by one-tenth of a grain of cocain, the extremities requiring one-fifth.

Dr. Lazard had had two cases. One of these, previously reported in November, was a case of fistula, in which 30 minims

of a 1 per cent. solution were used in two injections. Six minutes after the second injection the patient vomited, and nausea and vomiting continued all night. Dilation of the anus caused pain. His second case was one of diffuse phlegmon with high temperature. Two injections were made, the first 20 minims of 1 per cent. solution and the second 15 minims of 2 per cent. Shortly after the second injection the patient begged to have water thrown on his hands and arms, complaining that they burned intensely. Symptoms of collapse ensued, and were met with strychnin and digitalis hypodermically. In all ½ gr. of cocain in 35 minims of water had been used. There was no subsequent headache, but the vomiting was persistent.

Dr. Lazard alluded to about 40 cases in which Fowler used 20 minims of 2 per cent., and in all but two of which nausea, headache and vomiting followed. He also alluded to the distinction made by Foster between the effects of the loss of spinal fluid and the loss of cerebral fluid.

Dr. Chassaignac had had ten cases, three of which had already been published; others were mentioned by Dr. Delaup. He thought Dr. Martin's suggestion concerning concentration of solutions injected and consequent lessening of quantity was worthy of careful consideration, but only numerous observations and long experience could determine exactly where the line should be drawn; there is no doubt but that nervous excitement has something to do with the occurrence of the untoward symptoms. There are cases, though, which strengthen either side of the argument. He had one case, for instance, the results in which were ideal. Ten minims of a 2 per cent. solution were injected. The effect was perfect and there were no after symptoms. In another case where less was injected, some symptoms follows.

Dr. Chassaignac thought the word anesthesia improperly used in this connection, and suggested that it be discarded for the proper term, analgesia. In spinal cocainization, analgesia is the effect produced, pain is abolished, but not sensation. One of his cases illustrated this clearly; the patient stated that he could feel the contact of the instruments, but no pain. He had never injected large quantities of the fluid; believes in the concentrated solution theory, but thinks that so strong a solution as 10 per cent. should not be used, as it is too difficult to gauge

the quantity with accuracy. He had used the spinal injection chiefly in rectal operations, and found it required smaller quantities, which is noticeable in that with general anesthesia this organ is one of the last to submit, sometimes requiring dangerously deep narcosis. Therefore the new method is especially useful in these cases. Two only of his cases had marked after effects, one headache, the other vomiting. In regard to the mortality or efficiency, it is unjust to judge the method by cases which were rejected as unfit for general narcosis, as these are *ipso facto* unfavorable cases.

Dr. Genella suggested the necessity for more uniform reports, and stated that in several cases he had seen the analgesia seemed to be intermittent.

Dr. Dupaquier had witnessed Dr. Martin inject the spine in a case which he had taken to him for operation. The operation of injecting the spinal canal was quickly and easily accomplished, the operation for which the analgesia was produced was finished, and the patient never experienced any pain at all, nor the slightest sign of depression afterward. On the contrary, he expressed himself as feeling very well and he showed signs of the stimulating effects of cocain.

Dr. Larue had witnessed an abdominal hysterectomy under spinal anesthesia by Tuffier in the summer of 1900. On that occasion physicians from other sections of the United States were present, but New Orleans was the only city represented where the method had been used.

He reported a case from ward 7 of Charity Hospital in which the spinal fluid was evidently under considerable tension, as it spurted through the needle on puncture. Twelve minims escaped. Five minims of the solution were injected. Vomiting began on the table and continued 36 hours, cephalalgia 30 hours. He thought the anal sphincter was relaxed, the vesical sphincter was not. This patient remarked that he had been chloroformed 4 times, and had not suffered from headache or vomiting.

Dr. Storck, referring to the effects of cocain upon the organism, related the case of a woman whose throat he had sprayed with a one per cent. solution of cocain with antipyrin. She experienced nausea for about 48 hours afterward. He had had cocain used upon himself with the same effect.

Dr. Parham had noticed a very interesting phenomenon in

Dr. Gessner's case. The piston of the hypodermic syringe was protruded by the flow of spinal fluid through the needle after the injection had been made. No cocain could be tasted in the fluid in the syringe, showing that diffusion had taken place. Intra-spinal injection of other drugs have given rise to symptoms similar to those observed when cocain was used. In cases of death from simple lumbar puncture autopsies have usually revealed some cerebro-spinal disease, though the deaths have shortly followed the punctures. Tuffier says, when hypertension of the spinal fluid is shown, as by spurting from the needle on puncture, the unfavorable symptoms are less marked than when tension is low. Fowler gives strychnin in large doses to stimulate the circulation, thereby lessens the bad effects.

Dr. Mainegra believed that some of the after symptoms could be caused by nervous shock, as consciousness would admit of the nervous system's receiving such effects.

Dr. Perkins had injected 3 cases which are in the list reported by Dr. Parham. One of the patients had been chloroformed 4 times, and each time had suffered greatly from nausea. After the spinal injection he expressed himself as pleased with the noticeable difference in post-operative discomfort. Dr. Perkins stated that in the case reported by Dr. Parham in which chloroform was also used, he had thrust a knitting needle through a fold of skin, and the patient laughed at it. Afterwards he became frightened and became unable to discriminate between touch and pain.

Dr. Walet thought that inasmuch as there was some difference of opinion as to whether the after symptoms were due to the cocain itself or to the disturbance of tension, the point ought to be tested by injected sterile water.

Dr. Asher suggested varying the concentration of the solution used with the varying degrees of intra-spinal tension found.

Dr. Moss stated that other drugs had been used. He said that two of the cases at the hospital in which there were most after symptoms, were, one in which 15 minims had been injected with no loss of spinal fluid, and another in which 10 minims were lost.

Dr. Parham mentioned a case in which Goldan drew fluid from the canal, with which the cocain solution was made, and no bad effects were produced.

Dr. Gessner had had his attention called to the fact that perspiration was arrested over the anesthetized area in a case of his at the hospital.

Dr. Martin: "In closing allow me to thank you for the interest shown in this subject to-night. If I have done nothing else, I have at least had the matter pretty well discussed by the Society. I first believed that it was well to abstract about the same amount of spinal fluid as the amount of cocain solution injected. I now believe that this is an error, and only allow one or two drops to escape to feel positive that the canal has been entered. I agree with Dr. Parham and Dr. Chassaignac that 2 minims of a 10 per cent. solution is difficult to regulate; this was partly an experiment on my part. I shall confine myself to 5 minims in the future. Yesterday I injected 25 minims of a 2 per cent. solution in the spinal canal of a dog. In five minutes he seemed to have complete anesthesia, which in twenty minutes extended to the head, even the ears were insensible to pain pricks. When he was put on the floor he seemed to feel the touch of his feet on the flooring, but looked around to ascertain the cause. There were no after effects in this case."

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

The Closure by Bone of Skull Defects.—Victor Mertins, in *Deutsche Zeitschrift für Chir.*, Nov., 1900, gives his conclusions, as a result of his experiments on animals, carried out at the suggestion of Prof. von Eiselsberg, to determine the best means of closing defects in bone resulting from loss of substance.

1. Decalcified bone is useless for the closure of bony defects of the skull.

2. Burnt bone may indeed lead to the formation of bone, but necessitates long detention of the patient under treatment and requires the wearing of a troublesome protective cap.

3. Against the primary implantations of bone splinters may be urged, (a) the difficulty of shutting out the danger of infection, and (b) the smallness of the splinters which makes it impossible to fix them firmly in the defect.

4. The use of bone splinters laid loosely on the dura is not to be recommended, since experiments and experience show that a quick healing in of fragment and defect edge takes place only when both lie closely in contact.

5. Boiled bone answers every demand that may be called for in a good plastic material and has none of the objections pertaining to decalcified or to calcined bone.

6. Accordingly, bone splinters of sufficient size may, after they have been boiled, be successfully utilized.

7. In the use of a boiled bone plate the caution must be borne in mind that it must be as firmly as possible fixed in place and that the contact must be particularly close at those points of the edge of the defect where the diploë possesses the greatest vascularity. Furthermore, one or two bean-sized openings in the bone plate should be made to the end that no blood should collect under the bone.

8. The material should be taken from any human body.

In addition to these uses of bone thus treated, it may find useful application also to the treatment of pseudarthrosis of the extremities where the defect may be remedied without shortening, and in joint resection, by means of the interposition of pieces of the prepared bone, shortening may be avoided. Finally, in this bone we have a means of accomplishing firm arthrodesis, where indicated.

Von Bramann reported at the last German Surgical Congress a case of congenital tibia-defect, which he succeeded in curing by this means.

Gigli's Latest Modification of Instruments and Technic in Craniectomy with His Wire Saw.—In the December first issue of the *Centrblatt. für Chir.*, Gigli again returns to the great advantages of his wire saw in doing osteoplastic resection of the skull and presents some modifications of his instruments and technic well calculated to shorten the duration of the procedure. We

possess, he says, in the trephine, the chisel and the motor saw, sufficiently rapid means of opening the cranium; but the first does not give a large enough opening and sacrifices too much of the bone substance, the chisel causes too much trauma and the motor saw requires a costly and complicated apparatus. The Gigli saw method obviates all these objections, but up to the present he thinks it has not demonstrated itself to be a sufficiently rapid method. He has endeavored to improve the procedure by devising more rapid, and yet safe means of making the openings in the skull, and by so simplifying the apparatus as to facilitate greatly the passing of the saw.

He has discarded the motor in favor of the simple trepan, which he has succeeded in making much more effective and rapid, by modifying the apparatus for driving the borer through the bone. Taking the Collin trepanning machine as his starting point he has so improved the mechanism as to give a better and firmer hold against the skull and he has substituted for the trephine what is known in Germany as the "American borer," which he has guarded in such fashion as automatically to control its progress through the bone. Furthermore, he has so simplified the means of passing the wire saw under the bone as greatly to diminish the number of holes required as well as to decrease their size. This is quite simple. It consists of two metal staffs slightly curved at the lower ends, which, by a mechanism provided for the purpose, may be made to deviate from or approach one another, by turning the staffs on themselves; above is another arrangement for giving tension to the thread, passed through the curved part of each staff, which is hollow for the purpose. By simply turning the two staffs the two curved portions are turned away from one another and the thread is put upon the stretch. This is one part of the apparatus intended to catch the hook on the end of the steel wire which passes through a tunneled sound. This sound is so manipulated from the handle that it is not difficult to tell about where it is under the bone after having been passed through the first hole.

The borer is placed over this spot and the hole made. The thread carrier is then introduced with the two staff ends together. Once under, the two ends are separated, the thread thus put on the stretch and the hook sought. As soon as it is seen, the thread is easily made to catch it and the wire is pulled

through. We think this an improvement on his previous methods or any modifications suggested by others, even the watch-spring method of Lauenstein and Podrez, which we have found very useful and helpful in cadaveric osteoplastic craniectomy. Where the openings are not too far apart the danger of wounding the dura while sawing is not great, and this seems to be the only serious traumatism attending the method. A bone flap thus made is far superior to any that can be fashioned by any other plan. By bevelling it is so made (and the loss of bone substance by the sawing is so small) that it is impossible for the bone to fall in on to the dura; there is, therefore, no danger of hernia, and the bone apposition being so accurate, the union is rapid, and the danger of infection reduced to a minimum.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans, La.

Abdominal versus Vaginal Hysterectomy for Cancer of the Uterus.—That vaginal hysterectomy has failed as a satisfactory treatment for cancer of the uterus, and more radical procedures are being generally entertained, is amply illustrated by a recent discussion of the subject before the New York Academy of Medicine. Drs. Pryor, Boldt, Janvrin, Polk, Gill, Myer, Ramsay and Dudley expressed their views upon the subject, and while all did not speak in emphatic terms of their preference for the abdominal route, none doubted its efficacy in a large number of cases and admitted they were seeking methods offering a great deal more assurance than vaginal hysterectomy. Pryor advocated more radical treatment. Recurrence after operation was seen in the perimetric structures in ninety-six per cent., so a successful operation must remove not only the uterus and adnexa, but a considerable portion of the vagina and adjacent glands. These glands are in three groups. (1) The obturator glands, (2) the glands situated near the bifurcation

of the common iliac, (3) the glands of the utero-sacral folds. Removal of the obturator glands was the most important. The important point was that the immediate mortality must not be so high that one dare not depart from mere palliative means. A collection made abroad of 3155 vaginal operations gave a mortality of nine per cent., and he had himself shown that the abdominal operation in America was 11.8 per cent. Abdominal hysterectomy by progressive ligature is not the proper operation for cancer. The next fundamental principle was that in the act of removal all possibility of infecting the wound by either cancer cells or the particularly septic contents of a cancerous uterus must be avoided.

The first step in either operation should be a thorough curettage and cauterization which disinfected the mass and closed to a certain extent the mouths of the absorbents. He believes that in cancer of the cervix the sum total of human life saved by palliative methods was far greater by vaginal hysterectomy. In all the great clinics only seven per cent. of the women came within operable stage.

Dr. Boldt could not advocate either operation in all cases. Personally he thought that in only exceptional instances should abdominal hysterectomy be performed until we were in possession of facts proving its superiority over vaginal hysterectomy. The advantages of abdominal hysterectomy was that it permitted more extensive removal of the lymphatics and retroperitoneal glands. He doubted, however, whether it would give a larger percentage of recoveries because of the frequency with which the lymphatics were not involved even in the late stages. Time alone would settle this question.

Dr. Wm. Polk said his experience in this field had been so ghastly that he doubted whether he could add valuable material to the discussion. Of all the cases of cancer of the uterus upon which he had operated he had cured, he believed, only one, and all patients had died from recurrence of the disease. All operations hitherto offered were of but little value, being nothing more than an effort to make the patient's condition somewhat more tolerable. He had searched for some more extensive and radical operation, but even the more recent extensive operations seemed to hold out little encouragement. He preferred the more open field of abdominal route, because he had not been

able to do a sufficiently extensive operation through the vagina, though well knowing the seriousness of the abdominal operation.

Dr. Ramsay believed that in the greater number of cases the suprapubic method was preferable and believed it a mistake to attempt to adhere to any one operation. The combined operation might perhaps in the future be found more generally useful. Enlarged lymphatic glands does not necessarily mean that cancer has invaded them; the increase in size sometimes means mere hyperplasia.

Dr. Dudley would recommend the combined operation. It caused no more shock than the suprapubic alone. Dr. Porter also preferred the combined route, except in cases of extensive involvement, then only the vaginal route should be selected.—*Medical Record*, December 8, 1900.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

The Abortive Treatment of Pneumonia, Catarrhal and Croupous, in Infants and Children.—Can a pneumonic process in the infant and child be arrested at its outset, aborted? In spite of the fact, universally admitted "that the disease can not be cut short by any means at the present time," the author of the article now before us writes: "From my own experience I should answer the question affirmatively. I am certain that in infants and children the pneumonic process can be arrested at its outset, and more than that, that we have the means and have long had them, wherewith to do it." To demonstrate this, six cases are presented which are plainly illustrative. The remedies used were: 1. The combination of the tincture of aconite root with the tincture of veratrum viride; 2. The infusion of digitalis made with gr. x of powdered digitalis to ℥i of water. In the first form of medication the doses were of Tr. veratrum three-fourths of a drop and of Tr. aconite one-fourth of a drop, as shown by the following prescription:

Tr. verat. virid (Norwood's)	gtt. vi.
Tr. aconit. root	gtt. ii.
Dist. water	
Syr. of Tolu	aa. fl. ʒ ss.

As to the dose of digitalis infusion it was half a fluid drachm or thereabout as shown by the following prescriptions:

(a)	Infusion of digitalis	fl. ʒ ss.
	Spirits of Mindererus (recently prepared)	fl. ʒ ss.
(b)	Infusion of digitalis	fl. ʒ ivss.
	Dist. water	fl. ʒ iss.
	Ammonium carbonate	grs. v.
	Syrup of tolu	fl. ʒ ii.
(c)	Infusion of digitalis	fl. ʒiiss.
	Dist. water	fl. ʒiiss.
	Ammonium carbonate	grs. v.
	Syrup of tolu	fl. ʒii.

Teaspoonful doses were directed in both forms of medication. In the first, they were given in brief intervals, every hour and a half in cases of young infants, every half hour in cases of children. The digitalis infusion was given at intervals of two hours. Both forms were given for reducing the temperature and arrest the rapid wasting under the influence of the fever. The digitalis infusion was substituted for the acute and veratrum combination in cases of tumultuous action of the heart.

That the medication described did not merely reduce the temperature and leave the pathologic process going on in the body unaffected, just as would have been done by a dose or doses of antipyrin, phenacetin or kryofin is clearly demonstrated by the histories and graphically shown by the temperature charts. The temperature was reduced permanently, there was no further rise, even after the medicine was stopped. This could result only from an arrest of the inflammatory action, and the rapid change from a state of grave illness to a condition of well being are incontestible proofs of the quick and complete jugulation of the main factors in this morbid process, congestion and inflammation.

To this medication as to no other, applies the old adage: "*cito, tuto, jucundæ.*" It is rapid in action, it is safe and what is a matter of much moment in the treatment of children, it is pleasant to take.—H. Illoway, M. D. in *Pediatrics*, December 15, 1900.

Pneumonia in Persons Suffering from Obesity.—It affects an irregular type from the outset. The diagnosis is difficult and the prognosis most unfavorable. All cases are not fatal but very nearly so. The strain rapidly tells on the heart and its deficiency in tone brings about a sudden termination. The kidneys like the heart are also from the start severely involved, albuminaria is frequent and upon their function depends the prognosis; if deficient, it is absolutely gloomy. Altogether, the symptomatology is so unusual in each and every case, including as well the temperature tracing and the physical signs, that the utmost attention is required.—*Journal de Médecine et de Chirurgie Pratique*, December 10, 1900.

Nitric Acid for Gonorrhea.—This remedy has proved useful in the treatment of gonorrhea in the hands of Dr. Moriz Popper, of Budapest. He used it in the strength of 1 part of acid in 300 parts of water to 1 in 400. The injections are absolutely painless and are repeated four to five times daily. In one or two days the discharge becomes less in amount, the urin clears, and in two or three weeks a complete cure is effected. Where the gonorrheal process has extended into the posterior part of the urethra the author makes once daily a deep injection with a concentrated solution of the acid (½, 1, or even 2 per cent.). The author ascribes the good effects of the nitric acid to its property of coagulating albumin, and considers it superior to silver nitrate.—*Merck's Archives.*

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

The Use of Diuretics.—The following is from Therapeutics; its Principles and Practice, by H. C. Wood, M. D.:

"The chief indications for the use of diuretics are as follows:

"1. To maintain the action of the kidneys. It is hardly necessary here to discuss the necessity of excretion to the system. In various kidney diseases this indication is very urgent; but as

the lessened excretion too often depends upon a profound organic alteration of the renal secreting structure, it is evident that very frequently diuretics must fail when most needed. In the great majority of cases in which diuretics are used to fulfil the present indication, only the mildest of the class should be employed. Whenever there is inflammation of the kidneys, even if it be chronic, irritating diuretics should be avoided. When lessened urinary excretion is purely functional in its origin, diuretics are often most serviceable. In fevers especially is it necessary to maintain the action of the kidneys; for the purpose water should always be freely given during fever. The alkaline diuretics sometimes may be exhibited, but the most generally serviceable of all remedies of the class in the febrile state is the sweets spirit of nitre.

"2. To evacuate fluid. For this purpose hydrogogue diuretics are employed in all forms of dropsy.

"3. To soothe and diminish irritation of the genito-urinary organs. The value of water in fulfilling this and the next indication has already been pointed out. By lessening the acidity of the urine and rendering soluble the uric acid which is present, the alkalies are equally important in carrying out the present and the following indication.

"4. To alter the urinary secretion so as to prevent the deposition of calculous material. Notwithstanding it has been otherwise asserted, no practical measure has as yet been devised of dissolving a calculus when once formed. Even to alter the urine so as to prevent further deposition is probably impracticable, except in cases of uric acid or phosphatic diathesis."

PREVENTION OF GASTRIC FERMENTATION—

℞ Resorcin. resubl. ..... 5.0 (gr. lxxv.)
Bismuth. salicyl., pulv. rad. rhei, natrü sulphur. á á ..... 10.0 (gr. cl, about ℥ii ss)
Sacchar. lact. ..... 15.0 (gr. ccxv, about ℥iii, ℈ii)
M. Sig.—Make a powder; one-half teaspoonful twice daily.

—EWALD.

FOR CONSTIPATION WITH FLATULENCE—

℞ Extract. colocynth. co. ..... gr. ⅓
Terebinth. Veneta ..... gr. i
Pulv. aloes, socot ..... gr. iss
Ext. nucis vomic ..... gr. ¼
Ext. hyoscyami (English) ..... gr. i
M. ft. mass. et ft. pillul. No. 1.
Sig.—One (1) pill two to three times a day.

—ILLOWAY.

Treatment of Influenza: *Mild Form.*—However light the attack, the patient should remain in-doors for several days. A light and nutritious diet, and cooling drinks (lemonade, apollinaris, etc.) ordered. There should be a gentle movement of the bowels daily. An occasional dose of Dover's powder gr. x, monobromate of camphor gr. iss, should be given if there be much headache.

Quinin sulphate in 5 grain doses should be given every four or five hours.

Strychnin sulphate gr. 1-30 three times daily.

Medium Form.—Patients should go to bed, and remain there until convalescence is well advanced. Diet liquid in character, and given frequently in small quantities. Whisky or brandy in ℥ii doses well diluted should be given several times during the 24 hours. Cold sponge baths if the temperature be above 102 deg. F. For neuralgia use Dover's powder and monobromate of camphor. Quinin sulph,. salicylic acid or salicylate of sodium, when temperature range is high. Caffien citrate gr. ii, phenacetin gr. ii, for controlling insomnia. For sleeplessness, trional, sulfonal, opium. Steam inhalations (formicaldehyde, benzoin, etc.), or inunctions of animal fats over the forehead and bridge of the nose, if coryza be troublesome.

The following is useful to mitigate cough—

℞ Heroin ..... gr. iss
Ammon. muriat ..... ℥ii
Syr. picis ..... ℥ii
Syr. tolutan ..... ℥ii
Syr. pruni virgin ..... q. s. ℥v.
M. Sig.—Two (2) teaspoonfuls every three or four hours.

Codein sulphate gr. iii could be used instead of the heroin if desired. Turpentine stupes or mustard plasters to the chest. Strychnin sulphate gr. 1-30 every three or four hours day and night.

Severe Form.—Quinin sulphate in full doses, strychnin sulphate, digitalis hypodermically, bold stimulation. The various complications must be treated as they arise.—Ed.

The Treatment of Cancer of the Stomach.—Reed states in the *International Medical Magazine* for August, 1900, "that in gastric cancer lavage is the most important of all the forms of treatment, and in the cases with pyloric obstruction, with retention and dilatation, it is indispensable.

Condurango, a drug largely used in Germany, is believed now to be helpful mainly because of the good effect it has upon the accompanying gastritis.

This may be given in the form of the fluid extract in doses of a drachm or more three times a day, or, as preferred by Ewald, in a maceration decoction to which he advises the addition of appropriate doses of H. Cl. and some carminative.

It is necessary to overcome any existing constipation with douches of the colon, since they do not irritate the stomach, while they supply needed water to the body; though when moderate doses of mild laxatives prove effective, they may answer and are less troublesome and fatiguing. Diarrhea needs a more careful diet, antiseptic colon douches, and sometimes astringents with opium. Iron, arsenic and strychnin, when well tolerated, may be administered to enrich the blood, stimulate the appetite, etc.

Intragastric electricity, which in simple atonic dilatation, is our most powerful weapon, is ineffective and even harmful here. HCl and pepsin or some preparation of papaya may help the patient to digest more food.

Hematemesis is usually much less serious in cancer than in ulcer of the stomach. When it occurs, the patient must be kept at rest, recumbent.

All food by the mouth must be stopped, and the patient be caused to frequently swallow small pieces of ice. Sometimes small draughts of hot water are still more efficient. Twenty to thirty grain doses of bismuth in mixture with lime-water and a little essence of peppermint may next be tried, and these are very effective also in vomiting and diarrhea. The stronger astringents, as ergot, gallic acid, etc., should be reserved for stubborn cases. Extract of the suprarenal glands has been lately suggested as a safe and promising remedy. Three to five grains of the dried extract may be given several times a day.

External applications will sometimes relieve the pain of gastric cancer. Mustard, painting with iodin, and hot wet packs are the most easily applied, and will sometimes suffice. Among the milder internal sedatives, chloral and cannabis indica are frequently effective in allaying the pain and procuring increased sleep, and the former has useful antiseptic as well as sedative virtues.

Boas praises potassium iodide, especially in carcinoma of the cardia, and arsenic is thought to help in malignant growths anywhere. Methylen blue is beginning to obtain a reputation on account of some supposed sedative properties in gastric cancer. Most recent authors concede to it considerable efficacy. It is to be given in doses of three to five grains in a capsule daily, and Van Valzah and Nisbet advise that a little powdered nutmeg be combined with it, to correct its slightly irritant action on the urinary tract.

Marcus Fay recommends anilin sulphate, holding that it delays metastasis and cachexia and relieves the pain better than opium. But sooner or later in all cases opiates will become necessary. They can be given in any of the usual ways, but will be most effective hypodermically. Codein should be preferred so long as it continues to prove effcient, but at all hazards the patient should be made comfortable.—*The Therapeutic Gazette.*

Department of the Ear, Nose and Throat.

In Charge of Dr. A. W. de Roaldes and Dr. Gordon King, New Orleans.

A Case of Acute Leukemia of Tonsillar Origin. Dr. Cheroids Ferreri, of Rome, reports a rapidly fatal case of acute leukemia as being of tonsillar origin, and characterized by a marked enlargement of the faucial tonsils. The patient was a woman 34 years of age with a record of former good health, who came to consult for sore throat of one week's duration. This was accompanied by hemorrhages from the uterus, bowels and nose, oedema of the lower extremities, great thirst and loss of appetite. Temperature was subnormal, gastric region sensitive to pressure and vomiting frequent. Spleen not apparently enlarged, nor were any of the lymphatic glands affected. The tonsils were so large as to touch in the median line and gave rise to difficulty in swallowing and embarressed respiration. Surface of these glands hemorrhagic and covered with mucus, but were not ulcerated or indurated. The inner surface

of the cheeks, lips and the gums showed hemorrhagic spots. Louret's ergotin by injection was ordered, and aromatic stimulants given to combat the extreme depression. Examination of the blood showed enormous quantity of white blood corpuscles; the red were pale in appearance and irregular in form. Treatment was ineffective and death occurred in a general collapse from repeated hemorrhages and inanition.

The author concludes from the absence of the usual lymphatic and splenic involvement of leukemia and the prominence of the tonsillar lesion, that the tonsils were factors in the etiology of the affection. He considers this form of disease as belonging to the same category as Hodgkin's Disease.—*Annales des Maladies de l'Oreille, etc.*, December, 1900.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

At the Meeting of the Section on Ophthalmology, of the College of Physicians of Philadelphia, Two Cases of Intraocular Metallic Foreign Bodies which had been localized with the X-rays according to Sweet's method, were described by Dr. G. E. Schweinitz. In the one case the body was firmly imbedded in a mass of cicatricial tissue behind the ciliary body, where it had been for ten months, and although the magnet came in contact with the fragment it could not be moved. The eye was therefore enucleated, as sympathetic irritation had already set in. In the second case the foreign body was of unusual size, weighing 27 centigrams, and was easily removed about twenty-four hours after the accident. The collapsed eyeball was filled with physiologic salt solution, the wound closed with catgut sutures, and there was uninterrupted recovery; that is to say, the eyeball was saved, although, of course, the vision was greatly depreciated, being only light perception chiefly upon the nasal side of the field. He dwelt upon the uselessness of attempting to extract foreign bodies with the magnet if they

had been long imbedded, on account of the firm adhesions which necessarily are formed, and urged the importance of prompt surgical intervention after accidents of this character, stating his belief that it is imperative that eyes in which there was the least suspicion of a foreign body should be submitted to expert examination, if necessary, aided by the X-rays, so that no time shall be lost in localizing and extracting the foreign substance.

At this same meeting Dr. S. D. Risley exhibited a case of Abscess of the Orbit Following Injury, which proved to be associated with an opening into the ethmoidal cells, thus furnishing another illustration of the fact that suppurative disease of the orbit is usually associated with disease of one or more of the contiguous sinuses. The patient applied for treatment at the Wills Eye Hospital two days after a blow upon the nasal aspect of the upper eye-lid by a piece of flying metal. The upper lid was edematous, the conjunctiva chemotic, marked exopthalmos, and an almost fixed globe, only slight rotation inward remaining. Under cold compresses the pain promptly ceased, and the edema of the lids and exophthalmos disappeared, leaving only a point of tenderness at the upper and inner angle of the orbit. On the fifth day fluctuation was present, and a deep incision into the orbit was followed by profuse discharge of pus. A probe passed without resistance deeply into the orbit, showing a large area of denuded bone. The cavity was injected with peroxide of hydrogen solution and subsequently cleansed twice daily with saturated solution of boracic acid. The solutions passed freely into the nostril. Suppuration ceased after the first treatment and the wound healed without reaction or further suppuration. Mobility of the ball at the end of two weeks was completely restored and no tenderness remained. Dr. Risley found it difficult to explain the presence of the denuded bone, the opening into the ethmoidal cells, and the orbital suppuration following so speedily after the slight injury the boy received. There was no discoverable evidence in the nose of the ethmoidal disease having existed prior to the accident.

Miscellaneous.

Professor Robert Koch's Investigations on Malaria.*—Professor Koch, having become thoroughly convinced that the mosquito acts as the intermediate host of the malarial parasite of man, was recently detailed by the German government to make a thorough investigation of the subject, and to report on the best manner of combating this disease. All told, the government has spent upwards of $30,000, and the report is full of interest to all inhabitants living in a country where malarial fever prevails.

It must be remembered, however, that Ronald Ross, an English Army Surgeon working in India, was the first to prove (in August, 1897) that the spotted winged mosquito, genus anopheles, acts as this host, and the work of Koch and his expedition only goes to confirm the discovery of Ross. As is known, it is the contention of those who have done most work on the question that malarial fever is contracted in only one way, and that is through the bite of infected mosquitos, or mosquitos which have previously bitten persons suffering with malarial fever. Mosquitos simply carry the spores of malaria fever in their salivary glands, and it acts as the intermediate host for them in the same way as swine for the parasites of trichina; the tseste fly for the tseste disease; and the tick for Texas fever of cattle. In none of these hosts do the parasites give rise to any manifestations of disease. This is important to remember. Another important point is that the anopheles will always remain harmless provided it does not bite a person afflicted with malarial fever.

Professor Koch's Investigation of Malaria in Italy.—The first report made by Koch to the German Government dealt with the subject of malaria as determined by an investigation of the disease in the district of Rome and its vicinity. The full details of this report appear to have not been translated. All of the subsequent reports were first printed in the *Deutsche Medicinische Wochenschrift* and subsequently in the *British Medical Journal* for 1900 in the issues of February 10, May 12, June 30, September 1st and November 24.

*Abstract by Dr. Albert Waldert of Philadelphia, Pa.

Investigation of Malaria in Java.—The second report speaks of the malarial expedition under the direction of Koch in the Dutch Indies, where he arrived (Batavia) on September 21, 1899. The work began soon after his arrival, in the laboratory of the Military Hospital at Weltewreden, where cases of malarial fever were sent by the medical officer, Dr. de Freytag. It was found that in the town of Batavia malarial fever had diminished to a certain extent, which was due to the gratuitous distribution of quinin by the Government of Germany. This town obtains its water supply from artesian wells, but this water supply it was thought could have no effect on the diminution of the number of cases of malarial fever, since in the malaria-haunted harbors of Batavia at Tandjonk Priok, which is surrounded by marshes, malaria has not abated, although it also gets its water from artesian wells.

Malaria Not Transmissible to Apes.—The expedition secured ourang-outangs and three specimens of hylobates agilis, and one of hylobates syndactylus. These animals received injections of blood obtained from a case of tertian malarial fever, and subsequently as many infective experiments as possible, but none of them contracted the disease, and hence the conclusion was reached that if these animals, high in the scale of the animal kingdom, would not contract malarial fever, it could not be well supposed that other animals more remote from man can harbor the human malarial parasites. *Man, therefore, remains the only bearer of this parasite*—a fact of the greatest importance in regard to the prophylaxis of malaria.

Children as Tests of Prevalence of Malarial Fever.—Children are peculiarly susceptible to malarial fever.

In one village of mid Java it was found that the adults remained apparently healthy, but among 86 children examined 8, or 9.2 per cent., showed malarial parasites. This prevalence in the case of children is explained on the grounds that adults go through the disease during childhood, hence escape infection to a greater degree in later life. In another locality, of 141 children examined, 12 per cent. were malarious, while in another locality, of 189, 22.8 were malarious.

By examining the blood of children an absolutely trustworthy knowledge of the prevalence of malaria in a given community may be determined.

The expedition then went to Tosari in Java, where no mosquitoes exist, and after examining 82 children, not one was found to have malaria.

Mosquitos and Malaria.—Members of the expedition learned from experienced practitioners in Java that in regions where there were no mosquitos that no endemic cases of malaria could be found, hence these results confirmed the law—*where there are no mosquitos there is no endemic malaria.*

Forms of Malaria in the Dutch Indies.—Among 51 cases of malaria in Batavia and Ambarawa 8 per cent. were quartan, 45 per cent. were tertian, and 47 per cent. tropical fever (estivo-autumnal fever). On the contrary, in East Africa, where similar examinations were made, 89 per cent. were tropic fever.

Malaria in German New Guinea.—This, the third report made by Koch, begins by giving a detailed account of the investigation of the question around Stephansport. Here the investigations commenced in January (1900), and it was found that 21.4 per cent. of the population had malarial fever. This applies only to cases in which parasites were found in the blood. Speaking generally, there are no places absolutely free from imported malaria, since a man who has been infected in a malarious region may suffer from the disease, not merely for months, but *for years*, and may carry it about *everywhere*.

Studies carried on here regarding the prevalence of the disease among children confirmed the results obtained in Java, that a place in which a considerable number of children are found free from malaria must be free from endemic malaria.

Altitude and Malaria.—Altitude apparently exerts no influence over malaria. For instance Solkaboemi, which is free from malaria, is at a height of 602 metres above the sea level, while Bandoeng, which is grievously afflicted, is at a height of 1000 metres.

Acquired Immunity.—The expedition it is believed for the first time gathered tables showing the *natural immunity* enjoyed by inhabitants of malarious regions. The fact of acquired immunity was first observed in Java and further confirmed in the two New Guinea villages, Bogadjim and Bongu. In the former village those persons who had passed the fifth year, not one at the time examined had malaria fever, while among the infants it was found abundantly. In Bongu the experience was exactly

similar, except that in the latter place certain cases were found in the children up to 10 years of age. If in these instances only the blood from adults had been searched and erroneous conclusions might have been reached.

Immigrants from Non-Malarious Regions.—Immigrants coming from non-malarious regions are in exactly the same position as children born in a malarious country. They become quickly infected. European settlers going to this country all soon sicken with malaria as a rule, within the first three or four weeks; it is seldom longer delayed.

Among Chinese who had been engaged from 1891 to 1896, only 4.6 per cent. had malaria, while of another colony engaged in September and December, 1898, showed that 41 to 42 per cent. suffered with the disease. After three or four years it was found that an unmistakable degree of immunity developed the same as in the case of children.

How to Fight Malaria.—If the view be correct that the human malarial parasite is confined *only to mankind*, and not transferable to other animals, it must be possible that by destroying the parasites in the body of man to thus get rid of the disease.

A *person* is *never* free *from malarial fever until no further relapses occur.*

The most active remedy to destroy the malarial parasites and to prevent relapses is quinin. Fifteen grains of quinin (in fractional doses) is to be given the sufferer from malaria in the febrile intervals, therefore almost always in the morning hours until the malarial parasites have disappeared from the blood, then follows an interval of seven days, then again 15 grains on each of two successive days; then another seven days' interval; again two days' drugging with quinin, and so on for at least two months. In the instances in which this line of treatment was carried out there were few relapses, although the anopheles abounded and the patients were subsequently engaged in the upturning of soil, cleaning out ditches full of mud, etc.

Prevention of Malaria.—The fourth report, dated from Stephansort, April 28, 1900, deals with this subject. In this report Koch speaks of the period intervening between this date and the third report, the work of which was done during January and February of the same year. In the third report the

statement was made that he had tried to destroy the malarial parasites in man, and in this way hoped to bring about the disappearance of malaria in those regions. Favorable results had been obtained. In this the fourth report, he was able to state that this result has not been transient, as shown by the following figures:

Patients suffering with malarial fever were admitted to the hospital for colored people at Stephansort as follows: Chinese—January, 13; February, 6; March, 3; April, 1. Malays—January, 6; February, 5; March, 2; April, 1.

Malaria had, therefore, actually been reduced to a minimum in Stephansort, and at this, a time of year which, according to former years, is most favorable in respect to malaria. Beginning in November and December, the rainy season, malaria begins to increase, reaching its highest point in March and April, and subsiding in May. This year, owing to these measures, malaria, for the first time, exhibited an entirely different behavior. At this time there was no lack of mosquitos, especially anopheles. Most cases which showed a tendency to relapse were found to be the quartan type. At times new cases of malarial fever would be introduced by coolies coming from other localities.

The condition of the children at Stephansort was particularly noteworthy. Formerly, if they were not immediately taken to other districts, were always killed off by malaria; but later, three children placed under treatment all recovered.

Prophylactic Use of Quinin.—The same measures which answered so brilliantly in the treatment of malaria have also proved very useful for purposes of prophylaxis, as shown by the following: of coolies who came from the Gardner Islands, 47.7 per cent. were affected immediately upon their arrival. Those who have remained well had been taking quinin prophylactically, and not one of them contracted malarial fever.

In February, a number of Ambonese went to Friedrich-Wilhelmsafen. About one-half of them took malaria, while the other did not. The former remained well; of the latter, all fell ill with the disease with the exception of one woman.

The two members of the Malaria Expedition regularly carried out the prophylactic use of quinin and at the end of four months *neither had contracted malaria.*

Chronic and Mild Cases.—Koch draws close attention to the dangers arising from the chronic and mild cases of malarial fever, for these varieties are of the utmost importance in its eradication. It is held that the reason malaria shows an increase in the spring is due to the fact that many cases who *believe themselves cured still* carry the *germs in the blood throughout the winter* and upon the activity of the anopheles the next spring, malaria is thus spread broadcast. Cases in the chronic stage of malaria are to be found in which after a number of relapses the familiar symptoms become less and less marked. Pronounced attacks of fever occur only exceptionally or not at all. Patients of this description no longer feel themselves obliged to go to the doctor, so that the latter, if he does not make inquiries, generally learns nothing about such cases.

Besides the chronic cases, Koch believed that he had seen others which run so mild a course that they never reach the point of development of distinct clinical symptoms, and therefore could only be diagnosed correctly by an examination of the blood. (Ross calculates that it requires the presence of 250,000,000 malarial parasites in the blood to produce a paroxysm of fever.) In this respect malaria behaves just like the specific epidemic diseases, cholera, plague, etc., and as with these it is precisely the slight cases which are found by experience to require the greatest attention in combatting the scourge. If one confined one's attention to those patients who go of their own accord to the doctor, one would remove only a fraction of the malarial parasites. There remains, therefore, no other course than to subject all persons who in any way liable to harbor malaria parasites, and above all, children and recent immigrants, to *blood examination from time to time* in order, as far as possible, to discover all hidden cases and render them harmless.

After all these experiences Koch asserts that, *we are in a position by means of the procedure which he has described, to make every malarious* region *according* to *circumstances wholly or nearly free from malaria.*

Malaria Free Districts in New Guinea.—Koch afterwards visited Finchafen and the nearby villages and regions along the Huon Gulf to Cape Parsee and on Manlott Island without finding any cases of malaria. The same held true for Aramut Island where only a small number of children could be procured for a blood examination, but he met with no case of malaria.

It appeared therefore that the disease had not yet reached those regions. They nowise differ in regard to climate, soil, vegetation and water from the other islands, for instance the Tami Islands which are malarious.

On the Deslac Island, a group of the French Islands, blood specimens from a number of children were obtained and in this way the diagnosis previously made at a distance was confirmed.

Fifth Report of the Malarial Expedition.—The fifth report is dated Stephansort, New Guinea, June 15, 1900. During the last two previous months malaria at Stephansort had continued to remain at the low level described in the fourth report, although the climate had been particularly favorable for the development of the disease. Malaria in the tropics, as we know, is especially prevalent at the change of the seasons, both that from the dry to the rainy season, and *vice versa*. A changeable weather had caused no increase of malaria. In May only three cases had been admitted to the hospital, and for the first half of June only one. All four cases were relapses of the quartan fever, the mildest, but most obstinate form of the disease.

Principles of Campaign Against Malarial Fever.—The results obtained by this system of eradicating the disease adopted by Koch were quite enough to prove that the hypothesis on which he entered upon these researches were correct. They indicated the principles on which a campaign against malaria is to be conducted.

Means of Defence Against Mosquitos.—The prospect of exterminating the mosquito—a radical measure were it feasible—seemed to him remote. Mosquito netting offer some protection against mosquitos and against malaria. Another method is to keep off mosquitos by applying to the skin certain essential oils, which, in course of time, are apt to be injurious to the person, but the best manner of getting rid of the disease is to search out all cases suffering with malaria (diagnosed by a blood examination) and to cure them by the administration of quinin.

The 6th and last report of the Malarial Expedition speaks of the investigations carried on during August on the Caroline and Marianne Islands. At Ponape, Colonia and other places on the Marianne Islands 79 children were examined without finding any cases in which there was enlarged spleen or parasites in the

blood of those examined, and hence Koch concluded that these districts were free from malaria.

At Saihan, among 24 children examined, no case of malaria was found, therefore this island, too, was free from this affection.

Frambesia in the South Sea.—Among the many persons pointed out to him as suffering from syphilis, lupus and leprosy there were none actually afflicted with such diseases. What had been mistaken for them was frambesia, called by the English yaws. It is widespread in the South Sea, and is often mistaken for syphilis.

Malaria in Egypt.—Proceeding from Hong Kong to Suez the Expedition made a short stay in Egypt. Several endemic cases of malaria were found in Alexandria so that a genuine focus is to be found here. Other cases were found in Helouan near Cairo, and at Wadi Natrum west of the Nile Delta in the middle of the desert. (Ross explains the existence of malaria in deserts, on the grounds that the cases are to be found adjacent to cases where water and hence anopheles abound).

About Heredity.—In one one of his latest novels Pierre Véber with a pleasant stroke of humor turns to ridicule the affectation shown by those who speak of heredity and the fatalism attached to it. The author places before his readers a personage by the name of Prince de Thune, an old wag, who confesses his sins at the close of a hearty dinner, and this is what the Prince says:

"I hold for certain that atavism—in other words fatality in its modern form, bears heavily on each one's life. For my part, I feel that I am at the mercy of a multitude of influences which I term ancestral. By nature I am not bad and wicked, but within myself there is a dreary spot where a number of my ancestors meet like on a battle field, as it were, and engage in a fierce strife, and I can not help it.

"Temperance would be my predominant quality were it not for one of my nearest ascendants who opposes it with all his might. He was a captain of gendarmerie (police) in 1876.

"That man is towards me savagely tyrannical; any time I happen to see a glassful of brandy, he pushes my arm and compels me to toss it off, at once, that deadly alcohol. Work I always

thought to be man's destiny, and I would devote myself to it with all the fervor of my soul, but then one of my grandsires, a clerk in the government office in 1802, checks my earnestness. That man was hugely lazy.

"I am as gentle as a lamb, and I abhor any act of violence, believing that a gentleman should never beat a woman, even with a very short stick, yet I lose my temper like a madman, at times. I am prompted by a forefather of mine, a pedagogue, a dominie at the Montaign College in 1570, who would flog his pupils with all his might for any peccadillo.

"The mild cupidity I am guilty of comes from a tax-collector in 1405, a typical exciseman. To make a story short, there are but few sweet and discreet influences scattered here and there in my pedigree which counterbalance these evils by a feeble weight of virtues. Thus I can not but yield to the domination of two of my very first sires, the one a thief, the other a murderer. I mean Adam and Cain. I therefore give up resistance and let all that crowd scramble and do as they best may to rule my life. Think that every one like myself carries in his soul and heart a number of ancestors who slumber, arouse and act. To my mind, I picture them as very grave looking personages, with individual features. They walk about, within myself, to and fro, meet, greet, talk of things in the past and view the future. Suddenly, at some special prompting, they bestir, rush, forget their dignity, gesticulate, upbraid and engage in a free fisticuff and tumble. One should think he is in a madhouse, or at the Stock Exchange—the racket and uproar are simply deafening, stunning. Then comes a calm, still period; I rest, but expect some new alert. Indeed, the very next day the thing starts anew and will continue, I suppose, for a few more years until the moment I myself shall depart, to disturb the souls of my descendants."—*Variétés: Journal de Médecine et de Chirurgie Pratiques, 10 Dec., 1900.*

Degenerates and Marriage.—In many novels, chiefly of the present generation of well-meaning psychologists in France, the question of heredity has been seriously presented to the public. On the stage, science with its ominous prognosis of intermarriage of degenerates or of their descendants, has been

ridiculed; appeal to will-power being the remedy opposing the inherited evil influences at the time of their prompting and manifestations; will-power and resistance leading to triumph over consequences that seemed inevitable from the medical man's point of view. Whilst it is true that the moral treatment of degenerates in modern sanitariums has caused reform in many cases, it still remains a part of our solemn duty to oppose intermarriage of moral degenerates as we do physical degenerates. Were it so that physicians of sound judgment could prevent the follies of a decent Cupid as well as the ministers, legislatures and police could check the aberrations of sexual instinct, we would have an ideal world. But, how far from it do we now stand. Let us still look upon a degenerate of any description as a suspicious and a doubtful subject for marriage, even though he or she be reformed.—Ed.

As it Were.—Finding the arguments of her husband unanswerable, this ancient Egyptian woman confessed herself beaten. "You've got me dead!" she exclaimed, with emotion. "Then dry up," thundered the man, with a terrible look. This was plainly the natural order of things in those days.—*Literary Digest.*

En Passant.—First steamship passenger: "Did you have breakfast, sir?"

Second passenger: "Yes, for a while."—*Exchange.*

Tombstone Notes.—

"Here lies the body of Robert Gordon,
Mouth almighty and teeth according.
Stranger, tread lightly on this wonder,
If he opens his mouth you are gone to thunder."

———

"Sacred to the memory of Anthony Drake,
Who died for peace and quietness sake.
His wife was constantly scolding and scoffing,
So he sought repose in a twelve dollar coffin."

—*Exchange.*

Louisiana State Medical Society Notes.

The next meeting of the Society will be held in New Orleans, April 18, 19 and 20, 1901. Dr. F. W. Parham, New Orleans, President; Dr. H. B. Gessner, New Orleans, Secretary; Dr. Isadore Dyer, 124 Baronne street, New Orleans, Chairman Committee of Arrangements.

THE COMMITTEE OF ARRANGEMENTS calls the attention of members of the society to the approaching meeting and urges that titles of papers and subjects for discussion be sent in at once in order that they may appear on the preliminary program to be issued early in March. Members having papers on other topics than those submitted under the several sections for general discussion will please send titles to the Chairman of Committee of Arrangements before March 1.

SUBJECTS FOR GENERAL DISCUSSION—The following have been announced:

Section on Surgery.—Dr. E. D. Martin, Chairman, New Orleans. Subject for general discussion, Treatment of Fractures of the Long Bones of the Upper and Lower Extremities.

Section on Genito-Urinary Surgery.—Dr. Chas. Chassaignac, Chairman, New Orleans. Subject for general discussion, Treatment of Cystitis.

Section on Materia Medica and Therapeutics.—Dr. L. Sexton, Chairman, New Orleans. Subject for general discussion, Is the Tendency Toward Prescribing Proprietary Medicines Increasing; Its Final Effect upon the Professions of Medicine and Pharmacy.

Section on Ear, Nose and Throat.—Dr. O. Joachim, Chairman, New Orleans. Subject for general discussion, The Middle Ear Inflammations of Childhood and their Consequences.

The chairman of this section suggests that the subject of general discussion—Inflammations of the Middle-ear in Children and its Consequences—should be divided among the participants of this section for the purpose of *adequate* presentation of this important subject in its entirety to the State Medical Society. Those desiring to assist in this symposium will kindly communicate with Dr. Joachim, 124 Baronne street New Orleans.

Section of Ophthalmology.—Dr. E. A. Robin, Chairman, New Orleans. Subject for general discussion, When Not to Operate in Anomalies of the Extrinsic Muscles of the Eye.

Section on Dental and Oral Surgery.—Dr. A. G. Friedrichs, Chairman, New Orleans. Subject for general discussion, The Care of Children's Teeth.

Section on Nervous Diseases.—Dr. P. E. Archinard, Chairman, New Orleans. Subject for general discussion, Alcohol in Its Relation to Nervous Diseases.

Section on Quarantine and Sanitation.—Dr. E. Souchon, New Orleans, Chairman. Subjects for general discussion, The Prevention of the Spread of Contagious Diseases; The Period of Incubation of Yellow Fever.

Dermatology.—Dr. J. N. Roussel, Chairman, New Orleans. Subject for general discussion, Dandruff.

MEMBERS OF THE SOCIETY are earnestly requested to furnish the JOURNAL with items of interest about themselves, other members of the Society, or the Society itself, for publication in this department.

DR. S. D. BEVILL, a member of this Society, was shot and killed at Alexandria, in January, by Dr. C. J. Gremillion, as the result of some difficulty arising from a case in which both were interested.

THE RECORDING SECRETARY, DR. H. B. GESSNER, is authorized to sell to non-members copies of the 1900 Transactions of the Society at $1 apiece. Those members, if any, who have not received the 1900 Transactions will confer a favor by communicating with the Recording Secretary.

OFFICERS OF THE SOCIETY will find the time left between this and the date of the meeting (April 18th, 19th, 20th), none too long for the preparation of the reports expected of them.

Vice presidents in particular should take note of this.

Medical News Items.

The NEW ORLEANS POLYCLINIC CLASS contained during the month of January, the following gentlemen:

Drs. W. A. Barclift, Hartselle, Ala.; J. C. Harrod, Denning, Ark.; J. H. Wilder, Hooks, Tex.; G. A. Post, Simms, Texas;

O. O. Hamner, Bienville, La.; R. S. Bacon, Montevideo, Minn.; C. D. Johnson, Hare, Tex.; R. H. Jones, Wills Point, Tex.; Geo. A. Morrison, Thomasville, Ind. Ter.; F. P. Jones, Leesville, La.; W. H. Boykin, State Line, Miss.; M. B. Pollard, Winnsboro, Tex.; W. A. Daniel, Irwin, Texas; M. J. E. Estes, Deatsville, Ala.; W. E. Rucker, Cleveland, Tenn.; J. A. Adams, Hillsboro, Tex.; Chas. F. Schuford, Leon, Ind. Ter.; Theo. Buehring, Ottine, Tex.; B. H. Maynard, Lloyd, Fla.; T. J. Pressly, Runge, Tex.; W. Smith, Eldorado, Ark.; J. A. King, Santiago Papasquiro, Durango, Mex.; J. T. Boykin, Carrabelle, Fla.; H. C. McKenny, Kerens, Tex.; J. C. Strong, New Castle, Ark.; J. W. Molpus, Stinson, Miss.; H. H. Sykes, Junction City, Ark.; H. W. Aldridge, Plano, Tex.; W. H. Hendricks, Tifton, Ga.; J. H. Stone, Tremont, Miss.; J. F. Taylor, Booneville, Miss.; M. M. McMillan, Baldwin, Miss.; J. C. Bishop, Aucilla, Fla.; E. G. Calvert, West Monroe, La.

A Text Book on Special Surgery, by Dr. F. Koenig, and edited by Dr. Christian Fenger, is announced to appear soon from the publishing house of Herbert S. Stone & Co., of Chicago.

Mr. James Gibbons, nephew of Cardinal Gibbons, was shot by foot-pads, and on January 1st died of the effects of the wounds. Mr. Gibbons was an interne of the Charity Hospital at the time and was well thought of among his classmates and superiors.

Dr. J. B. Wheeler, of the firm making "Tissue Phosphate" recently died, but this will not effect the business of the firm.

The New Orleans Board of Health has been compelled to reduce the number of its inspectors from 25 to 10 because of the reduction of the budget of the City Council.

The Trustees of the New York Orthopedic Dispensary and Hospital announce that the Surgeon-in-Chief, Dr. Russell A. Hibbs, will give a course of clinical lectures on Orthopedic Surgery at the Institution, on Monday and Thursday afternoons, at five o'clock, from January 28 to February 28 (both inclusive). The course will be free to the medical profession and students.

The Third Pan-American Medical Congress Will Meet in Havana, Cuba, February 6 to 9, 1901.—A Southern Pacific steamer will leave New Orleans for Havana on the morning of February 2, dates of sale from interior points being so arranged as to enable passengers to reach New Orleans not earlier than three days prior to sailing date, February 2. Fare, $50 for round trip.

A rare opportunity is here offered for a visit to the ancient city of Havana and the Island of Cuba during the season when everything is at its best. The rates are exceptionally low, the sea voyage consumes less than two days each way, while the final limit for tickets sold for this occasion—thirty days—gives ample time in which to make an inland tour of the "Pearl of the Antilles."

Notice.—"I intend to publish a second paper on the use of the suprarenal capsule in organic heart disease. Will you kindly ask the readers of your journal to send me the reports of their cases as follows:

I.—The condition of the heart and pulse and pulse rate.

II.—The effect on the heart and pulse and pulse rate within ten minutes after the suprarenal powder, three grains, is chewed and swallowed without water, by the patient."

Yours truly,

Samuel Floershem, M. D.

218 E. 46th street, New York City.

Dr. Nicholas Senn, of Chicago, addressed the Tulane Medical Class January 25, on the subject of "Standing Between Life and Death."

Dr. J. T. Eason, of Grand Lake, Ark., was married to Miss Josie Thibodeaux of this city, January 10, 1901. The Journal extends congratulations.

The Vicksburg Medical Association has eleven members and meets the second Tuesday of every month. Dr. C. L. Mengis is Secretary.

Dr. Clarence Pierson has removed from New Iberia to Alexandria to practice his profession. The doctor has been taking a course at the Polyclinic.

Dr. W. E. Kittridge, of New Orleans, has been appointed assistant to Louisiana Insane Asylum at Jackson, and Dr. J. W. Sanders, who has been there, will locate at New Iberia, La., to practice.

Dr. H. D. Guidry, of Lafayette, La., was elected president of the Parish Board of Health at last meeting.

Dr. J. F. O'Leary, of Shreveport, has been appointed temporary surgeon of the Marine Hospital Service in place of Dr. A. R. Booth, who died last month.

The Town Council of Donaldsonville, La., has authorized the mayor to employ a physician to treat small-pox patients.

Book Reviews and Notices.

All new publications sent to the Journal *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* Journal *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Cancer of the Uterus, Its Pathology, Symptomatology, Diagnosis and Treatment. By Thomas Stephen Cullen, M. B. (Toronto), Associate Professor of Gynecology in the Johns Hopkins University. D. Appleton & Co., New York, 1900.

This superb book of 693 pages is characterized by the same beauty of type and profuseness of illustration as the work of Howard Kelly on Operative Gynecology, to which it seems a companion volume. The entire pathology of cancer and all pathologic changes likely to be confounded with it are exhaustively, but practically considered. The numerous illustrations, which in themselves cover the entire field of pathology, are by the well known artists, Brodel and Becker. The chief aim of the author has been to make plain the ways and means of recognizing cancer of the genital tract at the earliest possible stage, and with the abundant, well arranged material at hand he has succeeded in giving a relatively simple classification and adding much material of chemical importance. Especially valuable is the chapter on adeno-carcinoma, that form of

cancer so soon beyond surgical relief and which too often gives few signs of its presence. Many well selected reports of clinical cases and autopsies are introduced, each one having particular bearing upon the various forms of cancer under discussion. Taken as a whole the work is a most valuable contribution, especially because of its originality and eminently practical teachings. MILLER.

Saunders' Medical Hand-Atlas, An Atlas and Epitome of Diseases Caused by Accidents, by DR. ED. GALEFIENSKI. Translated by PEARCE BAILEY, M. D. W. B. Saunders & Co., Philadelphia, 1900.

The intention of this atlas and epitome is to present a description of the sequels of injuries caused by accidents. It contains forty colored plates and one hundred and forty-three illustrations in black, which alone make it valuable.

To the surgeon of experience the book is of little value, except for the fine illustrations it contains, but for the general practitioner it fills a great want. In addition to the illustrations, each of which is a lecture in itself, the author cites numerous cases on the subject. As these are culled from a collection of more than five thousand cases, the work pretty well fills its mission. The index is so arranged that the student can readily find the subject of interest, and the text will furnish a parallel for almost any accident case not out of the usual run, except in cases of injury to the eye, ear and female generative organs. MARTIN.

A Manual of Operative Surgery, by LEWIS A. STIMSON. M. D., and JOHN ROGERS, JR., M. D. Lea Brothers & Co., Philadelphia and New York, 1900.

The fourth edition of this work forms a valuable book. The first chapter is devoted to the accesssories of operations, and is thorough in detail. Every operation of importance is described in a most comprehensive manner. The illustrations are good, and aid materially in simplifying the description of each operation. The book is what the authors represent it to be, a manual of operative surgery, describing briefly, but minutely, one or more of the methods in vogue for the repair of injury or malformations. MARTIN.

A Treatise on Appendicitis, by JOHN B. DEAVER, M. D., Philadelphia. P. Blakiston's Son & Co., 1900.

This second edition of Deaver's work has been carefully revised, indeed almost rewritten. It is a thorough exposition of the subject by one who has had a most extensive experience and, as is well known, has most pronounced views on appendicitis. It will not only prove interesting to the special surgeon but to that very large class of general practitioners, especially in the country, where the most skilled operative assistance can not be secured in time for the many emergencies that arise in the course of this common disease, requiring often prompt and adequate treatment on the spot. PARHAM.

Fractures, by CARL BECK, with an Appendix on the practical use of the Rœntgen Rays. Philadelphia. W. B. Saunders & Co., 1900.

This is an eminently practical treatise on fractures. The special feature of the work is the constant reference to the X-rays as a valuable aid in the diagnosis and treatment of fractures, and the numerous radiographic illustrations throughout the book demonstrate their value. The discussion of the management of compound fractures is very thorough and practical and, indeed, throughout the work the advice given is clear and sensible, but perhaps the most conspicuous service rendered by the author is the showing of the practical bearing of the discovery of Rœntgen on the surgery of fractures. The illustrations are numerous and helpful.

PARHAM.

A Practical Treatise on Fractures and Dislocations, by LEWIS A. STIMSON, M. D. New York and Philadelphia. Lea Brothers & Co., 1900.

The second edition of this work was reviewed in this journal less than a year ago. We can add nothing but further commendation to what we wrote then of this standard work. It is undoubtedly the best work on Fractures and Dislocations accessible to English readers. The subjects have all been brought up to date, and although the time elapsing since the publication of the second edition is so short the changes in this have not been unimportant.

PARHAM.

Saunders' Question Compends: Essentials of Histology. By LOUIS LEROY, B. S., M. D. W. B. Saunders & Co., Philadelphia and London, 1900.

This addition to the well known quiz series of Messrs. Saunders & Co. will meet, we feel sure, with the desired approval of teachers of histology, because of the convenient and logical arrangment of the subject matter. Each chapter is complete and is concluded with a digest in the form of a sort of questions concerning the points salient in the preceding text. Over seventy illustrations are distributed through the book, making it the more useful on that account.

DYER.

The Care of the Consumptive, by CHARLES FOX GARDINER, M. D. G. P. Putnam's Sons, New York and London, 1900.

Written in an easy style, this little book of nearly 200 pages, considers the consumptive in each of its phases of his life. Chapters are presented dealing with the consumptive and the dangers of infection; the domestic hygiene is discussed and the questions of food, clothing, exercise, etc., are fully handled. A chapter on Colorado and an incidental discussion on climate conclude the book. An excellent bibliography is appended.

DYER.

Compend of Diseases of the Skin, by J. F. SCHAMBERG, A. B., M. D., Second Edition. P. Blakiston's Son & Co., Philadelphia, 1900.

Our favorable opinion of the first edition of this hand-book is in nowise altered by its revision. Carefully prepared for the student, it fills a wider

field in the conciseness of the text and in the superiority of the illustrations selected. The limitations of space necessarily compel some restriction as to detail, but the author has succeeded in presenting an admirable text, adequate in every way to the purposes for which it was written.

DYER.

The American Illustrated Medical Dictionary, by W. A. NEWMAN DORLAND, A. M., M. D. W. B. Saunders & Co., Philadelphia and London, 1900.

There are many dictionaries for the medical man, but each new one presents features of merit all its own. This may be said of the one before us. It is especially noteworthy for the convenience of its size and flexible cover, excellent binding and the detail of its type. Headings and subheadings are well brought before the eye and the definitions are concise as well as comprehensive. All words are given with their accepted phonetic pronounciation and with the ethymologic origin. DYER.

The Student's Medical Dictionary, by GEO. M. GOULD, A. M., M. D. Eleventh Edition. P. Blakiston's Son & Co., Philadelphia, 1900.

The fact of this being the eleventh edition of a popular dictionary testifies to the usefulness of the work. The present edition bears the imprint of careful revision and additions at the hands of the author, whose standing in literary medicine is alone sufficient to commend any product of his critical effort. DYER.

The Surgical Diseases of the Genito-Urinary Tract, Venereal and Sexual Diseases. By FRANK LYDSTON, M. D. The F. A. Davis Co., Philadelphia.

This treatise is divided into ten parts, as follows: 1. General principles of genito-urinary, sexual and venereal pathology and therapeutics. 2. Non-venereal diseases of the penis. 3. Diseases of the urethra. 4. Chancroid and complications. 5. Syphilis. 6. Diseases affecting sexual physiology. 7. The prostate and seminal vessels. 8. Urinary bladder. 9. Surgical affections of the kidney and ureter. 10. Diseases of the testis and spermatic cord. The subjects are well covered, brought up to date, and their consideration is sufficiently tinctured with originality to make the work more than a compilation. The text contains 233 illustrations and the letter press work is satisfactory. C. C.

Bacteriology and Surgical Technique for Nurses, by EMILY M. A. STONEY, superintendent of Training School for Nurses, etc., at Rock Island, Ill. W. B. Saunders & Co., Philadelphia and London, 1900.

The chief value of this work is the information contained in the chapters on surgical operations and the need of sterilization and the preparation of instruments, operating room, etc. The chapters devoted to bacteriology itself are, in our opinion, entirely foreign to the rest of the book, otherwise commending itself. DYER.

PUBLICATIONS RECEIVED.

United States Pharmacopoeial Convention—J. B. Lippincott & Co., Philadelphia, 1900.

Annual Report Mothers' and Babies' Hospital and Dispensary, 1900.

Proceedings of the Philadelphia County Medical Society, October, 1900.

An American Text Book of Physiology, Edited by Wm. H. Howell, M. D.—W. B. Saunders & Co., Philadelphia and London, 1901.

Panama and the Sierras, by G. Frank Lydston, M. D.—The Riverton Press, Chicago, 1900.

Proceedings of the Washington Academy of Sciences, by L. O. Howard, Ph. D.—Washington, 1900.

A Text Book of Pharmacology and Therapeutics, by Arthur R. Cushny, M. D.—Lea Bros. & Co., Philadelphia and New York, 1901.

Reprints.

Restitution of the Continuity of the Tibia by Transplantation of the Patella into an Extensive Osteomyelitic Defect, A Compact Operating Case for Military Service, The Physician as a Scientist, by N. Senn, M. D., Chicago.

Harmonic Vibrations as a Therapeutic Agent, by W. Xavier Sudduth, M. D., Chicago.

Estimation of the Amount of Injury to the Earning Capacity of the Individual from Partial or Complete Loss of Vision, by Howard F. Hansel, M. D., Philadelphia.

Malaria--Is it Mosquito borne?

Indications for the Drainage in Diseases of the Biliary Passages and the Technic of Operation, by J. E. Summers, Jr., M. D.

Aseptic Minor Gynecology, by Augustin H. Goelet, M. D.

Proctorrhaphy: The suspension of the rectum for the Cure of Intractable Prolapse and Inversion of that Organ; Mephrorrhaphy: Address in Obstetrics, by Charles P. Noble, M. D.

The Failure of the Consensus Judgment with Reference to Tuberculosis, by Chas. Denison, M. D.

Abdominal vs. Vaginal Hysterectomy, by Henry C. Walker, M. D.

When is Contract Practice Unethical, by Will B. Davis, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR DECEMBER, 1900.

CAUSE.	White.....	Colored...	Total.....
Fever, Malarial (unclassified)	1	.....	1
" " Intermittent	.....	.....	.....
" " Remittent	3	.....	3
" " Congestive	5	1	6
" " Typho	.....	.....	.....
" Yellow	.....	.....	.....
" Typhoid or Enteric	7	3	10
" Puerperal	.....	.....	.....
Bronchitis	16	9	25
Cancer	16	4	20
Consumption	37	34	71
Diphtheria	3	.....	3
Influenza	3	1	4
Measles	.....	1	1
Whooping Cough	.....	.....	.....
Pneumonia	34	31	65
Diarrhea (Enteritis)	14	3	17
Dysentery	4	1	5
Gastro-Enteritis	6	2	8
Hepatitis	3	2	5
Hepatic Cirrhosis	6	1	7
Peritonitis	1	1	2
Debility, General	.....	1	1
" Senile	13	4	17
" Infantile	4	3	7
Bright's Disease (Nephritis)	24	16	40
Uremia	3	1	4
Heart, Diseases of	47	22	69
Apoplexy	11	2	13
Congestion of Brain	4	1	5
Meningitis	4	2	6
Tetanus, Idiopathic	.....	.....	.....
" Traumatic	2	2	4
Trismus Nascentium	.....	4	4
Injuries	19	14	33
Suicide	3	2	5
All Other Causes	76	65	141
TOTAL	369	233	602

Still-born Children—White, 31; colored, 12; total, 43.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 21.08; colored, 31.06; total, 24.08.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.13
Mean temperature	56.
Total precipitation, inches	5.81

Prevailing direction of wind, northeast.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. MARCH, 1901. No. 9.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

COCAIN AND EUCAIN IN LOCAL ANESTHESIA, AS APPLIED BY THE COMBINED INFILTRATION AND REGIONAL METHODS IN MAJOR SURGERY OF THE EXTREMITIES, WITH ILLUSTRATIVE CASES.

BY BURDETT ATKINSON TERRETT, M. D., NATCHITOCHES, LA.

The discovery of ether and chloroform, something over half a century ago, and their introduction and permanent use in medicine as general anesthetics, infallibly marked an epoch in the annals of medical science, hitherto almost without a parallel, and, unquestionably, gave to the strides of surgery and general medicine an impetus, the force and salutary effects of which are keenly observed and felt by every practitioner in the daily pursuit of his avocation; but, scarcely less valuable, and, indubitably none the less startling and revolutionizing, was the consummate and successful application of cocain in minor surgery something over a decade ago, as a sequence to the experiments and subsequent announcement of this drug in ophthalmologic surgery by Carl Kolber, of Vienna. Through thorough and systematic study, assiduous and indefatigable investigation, not merely the feasibility, but the practical utility of local anesthesia in minor surgery was soon amply confirmed and its success assured.

The advent and experimentation with eucain in the field of minor surgery during the past five years has proved its efficacy, and has demonstrated beyond all suspicion or incertitude, that a notable acquisition has been made to the catalogue of local anesthetics. Since these agents have proved of such positive and unqualifying success, persistent and strenuous efforts have been directed towards broadening their scope, and augmenting their sphere of usefulness, and, so marked and striking have been the results in this direction, that no longer can these agents be said to be confined to the strict domains of minor surgery, for, indeed, the results as obtained through the sedulous, painstaking and magnificent work of Corning, Haize, Barker, Tuffier, Schleich, Beer and others, has served to place these agents beyond the pale of minor, into that of major surgery, and their reliability and efficacy, when applied as is so judiciously advised and described, absolutely can not be controverted or gainsaid. The consideration of the extensive local anesthesia beyond the limit of minor operations, has eventuated in the evolution of several distinct and separate methods for its successful application, and I allude particularly to the methods inaugurated and designated as the infiltration and regional methods, for 'tis of the combined infiltration and regional that I especially wish to speak. I shall refrain from entering into even a hasty or cursory review of the most salient points in the history of local anesthesia, for it would in a manner be foreign to the object, and would render burdensome this paper which is intended merely as a form of concise and tenable argument for the more general use of the combined method ,and the advisability of carrying this procedure, whenever feasible, clear into the lines of major surgical work.

The intradermal, intrastitial or infiltration method, which consists merely in forcing the analgesic fluid into the derm proper by means of an ordinary hypodermic syringe, and which is so universally familiar, was first practiced and afterwards announced by Halstead and subsequently developed and popularized by Schleich, by which the latter conclusively demonstrated the efficiency of attenuated solutions, such as 1 per cent., 1-5 of 1 per cent., and even 1-10 of 1 per cent. solution of cocain in contradistinction to the hitherto almost universal usage of the potently active and dangerous solutions of 4 per cent., 6 per cent., and not unfrequently 10 per cent.; my allusion, therefore, to the

Schleich infiltration method—as it is frequently denominated—is simply upon the basis of attenuated solutions, or relatively speaking, a minimum quantity of the anesthetic in a modicum of sterile water at ordinary temperature, rather than the special technic as devised and exploited by Dr. Schleich, whereby morphin sulphate and sodium chloride are added to the solution.

The inter, peri, or para-neural method, or, as it is sometimes referred to, the Corning method, more correctly known at this hour as the regional method, whereby the fluid of anesthetization is thrown into, around, or in close proximity to the nerve trunk, with the concomitant analgesia of the terminal or peripheral sensory fibres, was first probably achieved by Hall, though it remained for Corning and others, through a series of long and well conducted experiments, to ultimately prove its absolute practical utility and point with emphasis to this signally new and triumphant departure in the employment of the aforementioned anesthetics. I take it, then, that the infiltration and regional method which is popularly referred to as the Schleich and Corning, is too thoroughly comprehended to require any special consideration or elucidation, and I herewith append several illustrative cases as pointing towards the great practical bearing and value of the combined methods, and which, through the courtesy of Drs. Matas, Parham and Larue, I am privileged to report.

CASE NO. I, By Dr. Felix Larue.—Resection of the 4th and 5th meta-carpal bones, under cocain anesthesia, for traumatic suppurative osteitis.

ANAMNESIS.—Octave D., white, male, native of Louisiana and a farmer by occupation. He was admitted to ward 9 in the Charity Hospital February 27, 1900, suffering from two persistent suppurating sinuses in the outer dorso-lateral aspect of the right hand, as a result of an accidental gunshot injury some four years before. No history of the escape of spiculae of bone from sinuses could be obtained, but the constant purulent discharge associated with palpable ankylosis at the fourth and fifth meta-carpal articulation suggested some degree of osseous lesion, and a probe was introduced into the mouth of one of the sinuses to determine more accurately and definitely the exact status of affairs. The probe at once impinged upon distinctly exposed bony surface, and upon further manipulation revealed an

extensive denudation of periosteum with softening of the osseous structure through a large part of both bones. A diagnosis of osteitis was made, which was subsequently verified by the operation. Examination of the heart, lungs and kidneys showed the organs to be intact, but a history of chronic alcoholism, substantiated by the general appearance of the patient bespoke him as an illconditioned subject for the general anesthetic, and cocain was selected as the most preferable and least dangerous mode of allaying pain. The combined infilration and regional was deemed the most feasible and rational procedure; a 1 per cent. solution was employed.

Operation.—Owing to slight excitability on the part of the patient, and apprehensive lest this might become intensified during the very incipiency, and thereby militate largely against the successful application of the anesthetic, a primary hypodermic injection of morphin gr. ¼ was resorted to fifteen minutes prior to the operation. The constriction was now applied to the upper one-third of the arm, and the following nerves were exposed consecutively and in the location herewith designated, after having previously deadened the cutaneous and epi-neural tissues, by the infiltration method (see accompanying chart). The median was exposed in the cubital fossa by a 6 centimeter incision, the ulnar was procured by a 2 centimeter incision between the internal condyle and olecranon process, and finally the musculo-spiral, by a 4 centimeter cut in length immediately above the external condyle. In each instance the nerve was detached from its adjacent or enveloping structures, brought clearly into view, and intra-neural injection practiced. (See chart). The incisions made for the exposure of the nerves, as just enumerated above, were not sutured instantly; simple replacement to their former position was done, and the wounds left protected by sterilized gauze, in order to render them easily accessible for infiltration, should this become requisite by the occurence of pain at any time during the course of the operation.

The anesthetic acted with almost magic celerity, and, in less than two minutes, the entire hand and forearm were completely dead to painful sensation. The operation proper was now commenced. An incision was made on the dorsal surface at the carpo-metacarpal articulation of the fourth and fifth meta-

carpal; it was then carried downward between the third and fourth metacarpals throughout their entire length; the incision was then prolonged to the palmar surface, between the middle and ring fingers, and thence carried outward, striking the dorsal margin of the hypoctrinos region, and finally connecting with the original dorsal cut above. The cutaneous and subjacent tissues of the hypothenar and palmar surface proper were dissected clear of the bones; the fourth and fifth metacarpals were well defined, then disarticulated, and the palmar flaps brought to the dorsum and stitched.

REMARKS.—The operation consumed only 20 minutes, and was altogether devoid of pain, save for the presence of the constrictor which induced some slight discomfort during the latter part of the performance. The wound healed without incident, and, there was no development of neuritis or manifestation of disturbance of function whatsoever, in the course of the nerve trunks and their branches. A slight tingling, and very little pain in the field of analgesia, occurred about 10 or 15 minutes following the operation, and, was only ephemeral as to duration.

DR. F. LARUE'S CASE.

Time of injection.	Quantity.	Remarks.
		Constrictor applied at 10:45 A. M.
		Morphia ¼ at 10:51.
10:53	25 M. $\frac{1}{50}$ % Sol	Infiltration.
10:54		
10:56		
10:58		Median nerve exposed.
10:59	10 M. 1% Sol	Regional.
11:02		Finished.
11:03	25 M. $\frac{1}{50}$% Sol	Infiltration.
11:04		
11:05		
11:06		
11:09		
11:10	6 M. 1% So	Ulnar nerve exposed.
11:13		Regional.
11:17	25 M. $\frac{1}{50}$% Sol	Finished.
11:18		Infiltration.
11:19		
11:21		
11:22		Musculo Spiral exposed.
11:24	10 M. 1% Sol	Regional.
11:25		Finished
11:27		Anesthesia complete.

Case No. II, by Dr. Rudolph Matas.—Sub-astragaloid amputation of the right foot for tubercular osteitis of the scaphoid, internal cuneiform and os calcis, under cocain anesthesia.

Anamnesis.—Frank S., white, male, aged 32, and a farmer by occupation. He received admission into the Charity Hospital December 18, 1899, and gave the following as a history of his condition: The primary trouble began about eight months previous, when the patient commenced to suffer with slight transitory pains in the right foot, which came on insidiously (no history of traumatism) and at first merely occasioned him some annoyance, but after a brief period of time—about three weeks—the pains became more frequent, more intense, and less transient in character, and were particularly exaggerated after much foot service—viz: walking, standing, and the like. About a month after the inception of the initial pains, the patient observed a gradual augmentation in the size of the diseased member, and especially was this referable to the outer dorsal aspect, just anterior to the external malleolus, when a circumscribed and tumefied spot resembling a hen's egg in contour and dimensions could be plainly discerned. This condition prevailed for about one week when the protuberant part just alluded to ruptured spontaneously and evacuated a quantity of pus, characteristically cheesy in character; concomitant with this incident came a partial relief in the symptoms, there was a diminution in the general swelling of the foot and an appreciable cessation in the pains, but, an inveterate discharging sinus—expelling curdy pus—associated with the constant tumefaction and continuous soreness, incapacitated him largely for the pursuit of his avocation and he ultimately sought the hospital for relief. Inquiries leading into a personal history indicated the existence of a pulmonary tuberculosis extending over a period of several years. There was a negative family history of this condition. Physical examination disclosed a cavity in the upper lobe of the right lung, kidneys were normal, but the heart's action was weak, though no organic lesion could be detected. Examination of the diseased foot revealed a couple of sinuses on the dorsal surface from which cheesy pus could be seen to escape, and, upon introducing the probe, a large area of diseased bone, involving the tarsus anteriorly could be readily detected. A condition of tubercular osteitis suppurativa was

diagnosed, which was confirmed by the operation. A general anesthetic was proposed, and the patient was stimulated and toned up for several days in advance, in order to successfully meet and combat the shock from the dual effects of the operation per se and the anesthetic itself.

OPERATION.—A general anesthetic was started—chloroform beingused—but the patient entered directly into a violent stage of excitement, and when in the very acme of the struggle, sank into a perfect state of collapse, from which, with difficulty, he was finally resuscitated. The necessity of permanently suspending the chloroform was now obvious, and it was determined upon to at once institute the combined infiltration and regional methods as the most available for alleviating the pain of the operation. Solutions of cocain hydrochlorate, one-fifth of one per cent. and one per cent. were proposed, and after a preliminary hypodermic injection of morphin, gr. ¼, the constrictor was applied to the upper one-third of the thigh and the leg exposed for the operation. The skin was edematized for a distance of one decimeter in the vertical line immediately above the upper angle of the popliteal space with 8 *c. c.* of a one-fifth of one per cent. solution, and an incision carried perpendicularly through the skin and subcutaneous tissue to the seat of the great sciatic, which, after being identified, was detached from its surroundings and moved well into the mouth of the wound. The intra-neural method was now employed and 2 *c. c.* of a one per cent. solution introduced directly into the nerve trunk, after which it was replaced in its original bed. The lips of the wound were left ununited and it was protected as in the previously quoted case. In less than three minutes there was almost absolute deprivation of painful sensation below the point of infiltration. The line of incision was now mapped out and the operation executed in the following manner: An incision connecting the two malleoli anteriorly, which was carried directly over the tarsus, was first made. The incision was then prolonged from the internal malleolus, brought under the plantar surface and slightly forward, finally connecting with the primary dorsal cut behind. The plantar flap was well dissected towards the heel, and the tarsus, exclusive of the astragalus bone, removed in its entirety and the plantar surface brought to the dorsum and stitched according to the usual plan.

Remarks.—The operation consumed about 30 minutes, and half an hour after its completion there was restoration of normal function in the nerve trunk and its tributaries. No symptoms of neuritis developed, the initiatory incision for the exposure of the sciatic healed promptly, and, the stump progressed kindly and to a final cure. The quantity of cocain utilized in the intra-neural injection approximated 12 *c. c.* and, about an equal quantity was consumed for the infiltration process; apart from slight pain when the dorsal incision was made, and the terminal fibres of the long saphenous encountered, it was, in every detail and particular a perfect success.

Case No. III.—Osteo sarcoma of the upper alveolar process with resection—under cocain, by Dr. Rudolph Matas.

Anamnesis.—George B, white male, aged 50, married, occupation that of laborer. Was referred from the Out Door Clinic to the surgical ward of the Charity Hospital for treatment of a rapidly growing and painful growth involving the alveolar process of the upper jaw, directly under the superior labium. The history as de livered by the patient, showed the growth to be of obscure origin, there was no remembrance of antecedent traumatism, no evidence of carious teeth, in fact, the onset was altogether insidious, and, the history entirely free from any explicable causa-tion of the trouble. The first intimation suggestive of the malady occurred about 4 months previous, when the patient noticed a small nodule about the size of a bean situated on the gum just above the central incisor teeth, which was indurated and ordinarily insensitive. Its presence, at first, offered no inconvenience or discomfort, owing to its diminutive proportions, but in the course of a few weeks the mass showed a decided proclivity to enlarge, and its encroachment upon the labium became very perceptible, as was evidenced by the marked outward projection of this latter. Associated with this tendency to enlarge, there was not infrequently annoying pains in the part, and the continuance of this latter, in conjunction with the rapidly growing character of the tumor, occasioned the patient so much discomfort, and, finally, alarm, that he applied to the clinic for treatment. Examination disclosed a circumscribed, elevated and hard tumor in the gum, immediately under the upper lip, about an inch in diameter and somewhat sensitive to manipulation. The mass seemed apparently osseous in char-

acter, and, upon a more circumspect investigation, showed that it sprung directly from the alveolar process. Physical examination showed an absence of pathologic change in the various organs—as heart, lungs, kidneys, etc. The possibility of the syphilitic character of the growth was not wholly ignored, but the personal history and clinical evidence were sufficient to eliminate suspicion in this regard, but, to demonstrate more lucidly and satisfactorily the non-existence of this malady, the specific confirmatory therapeutic measure was instituted, and potassium iodide, in ascending doses until the maximum was reached, was administered, but this failed entirely to diminish, or even hold in abeyance the rapidly growing tumor; malignancy was now diagnosed with a possible inference of its being sarcomatous in character, which latterly proved to be correct, as was evidenced by the microscopic returns. Removing of the tumor was early settled upon, and the suggestion of a local anesthetic for the abolition of pain was acquiesced in with alacrity by the patient, who was averse to the taking of chloroform or ether.

OPERATION.—The solutions selected in this case were 1-5 of 1 per cent. and 1 per cent.

It was considered a practical procedure to essay the combined method in the extirpation of the growth by anesthetizing the two superior maxillary branches of the trifacial on the floor of the infra-orbital canals for several centimeters beyond the foraminal orifice, by means of an extra long hypodermic needle; accordingly, everything was arranged for this mode of application, and the operation commenced by the usual routine plan. First, the tissues overlying the infra-orbital foramina were infiltrated with a 1-5 of 1 per cent. solution, 3½ *c. c.* being employed in each instance. A hypodermic syringe charged with 2 *c. c.* of a 1 per cent. solution and armed with a needle at least one decimeter in length, was now held in readiness and the anesthetizing of the nerves proper attempted, to-wit: The needle was introduced directly through the edematized field, thence carried straight down to the exit of the nerve. The foraminal orifice was now sought for, and was of easy access. The needle was carried into the canal for several centimeters and the nerve injected, while the needle was forced in at the outlet, thus deadening the nerve, from the beginning of the foraminal opening.

The opposite canal was sought for, and located in the manner just described, and intra and peri-neural injection practiced in identically the same way. Analgesia of the parts supplied by the superior maxillary branches coming from the infra-orbital canals was now well marked, and the tumor and surrounding tissues were unmistakably insensitive. The tumor was extirpated and a large portion of the alveolar process on the left side was also cut away. Except for some pain experienced when the incision was carried posteriorly and beyond the line of anesthesia, the operation was entirely a success.

Remarks.—Seven *c. c.* of a 1-5 of 1 per cent. solution was employed for the infiltration, and 3½ *c. c.* of a 1 per cent. for injecting the canals. There were no subsequent unfavorable symptoms attending this operation.

Case No. IV.—Hepatic abscess with resection of 5 centimeters of the 8th rib under eucain "B," by Dr. Frederick W. Parham.

Anamnesis.—Alfred L., white, male, aged 27, single, and a laborer by occupation. Was admitted to the Charity Hospital January 8, 1900, suffering from a supposed hepatic abscess. The primary trouble, as elicited by the history, commenced about the middle of December, 1899, when the patient had a very severe and obstinate attack of dysentery, which, after several weeks' duration and under prompt and careful attention, gradually subsided, but following upon this, some two or three weeks subsequently, symptoms characteristic of hepatic abscess began to manifest themselves, namely, bulging and tenderness in the right hypochondrium, with intermittent pains in the right shoulder—sometimes dull, at others lancinating, and referred especially to the supra-scapular region, also pyrexia, with frequent and, at times, copious sweats. On admission into the ward, examination revealed a prominent swelling in the right hypochondrium, extending for several centimeters in the vertical line, and decidedly sensitive to pressure, while upward and outward divergence of the costal arch was palpably clear. Temperature 103 deg., pulse 140 and dangerously poor in quality. The patient's general physical status was appreciably bad, and marked emaciation, with every positive evidence of profound sepsis, was present. Surgical intervention wss immediately decided upon and the patient prepared for operation. Owing to the terribly depressed state of the patient, it was thought un-

warrantable, if not wholly contra-indicated, to proceed with a general anesthetic, and it was proposed to adopt a local measure, eucain "B" being selected, and the following solutions were prepared: 1-5 of 1 per cent., 1 per cent., and 4 per cent.

OPERATION.—Primary operation was resorted to, the needle being introduced in the inter-costal space of the seventh and eighth ribs, at a point corresponding to the axillary line, and a $\frac{1}{5}$ of 1 per cent. solution was utilized for deadening the tissues at the site of puncture. The appearance of the characteristic chocolate colored pus corroborated the diagnosis, and resection of the eighth rib was deemed the most feasible and expedient procedure. The tissues were edematized for about 1 decimeter immediately over and along the direction of the eighth rib, with a $\frac{1}{5}$ of 1 per cent. solution, and an incision made through the line of anesthesia and the periosteum exposed, but the peculiar and exaggerated sensitiveness of this membrane necessitated ulterior utilization of the anesthetic, and a 1 per cent. solution was injected directly into the part, covering an area of fully 5 *c.c.* The abolition of pain was soon established and the periosteum dissected clear of the osseous structure for a half diameter in length, but manipulation under the lower border of the rib seemed to engender the most exquisite pain, ostensibly from the propinquity of the inter-costal nerve, which was now practically indexed by the successive jets of arterial blood emanating from one of the lacerated ends of the inter-costal artery, which had been wounded in the uncovering of the bone. A 4 per cent. solution was next selected, and intra as well as perineural injection performed, which culminated almost instantly in the absolute obtunding of painful impression in the periosteum and immediately underlying tissues for several centimeters anterior to the part injected. Eight centimeters of the rib were at once resected and the incision prolonged to the diaphragm, but slight sensitiveness of this organ as well as Glisson's capsule, when this latter was approached, demanded further use of the eucain, and a 4 per cent. solution was again employed. The suturing and subsequent manipulation of the tissues failed to elicit one word of complaint or protest from the patient; in truth, entire anesthesia for a couple of diameters beyond the line of incision was categorically marked.

REMARKS.—Only a minimum amount of pain was experienced

during the whole procedure, no necrosis of the tissues resulted, nor did a single unfavorable symptom ascribable to the eucain occur, although two-thirds of a grain was used for the operation.

Conclusions.—From the foregoing catalogue of cases I would summarize as follows:

(1) That cocain and eucain are undeniably the most potent, efficacious and reliable local anesthetics now in general use.

(2) That the agents in a menstruum of simple sterile water at ordinary temperature, and when freshly prepared, give entire satisfaction, and, when injected in the proper manner, can be made to engender the most profound and complete anesthesia.

(3) That cocain and eucain must infallibly supplant a general anesthetic, whenever this latter is contra-indicated by some organic lesion, whereby its use would be a menace and directly endanger the patient's life.

(4) That the combined infiltration and regional method is of unquestionable value, and its practical usefulness confined especially to those parts where the nerve distribution is easily accessible—notably the extremities and ribs.

(5) That the entire absence of any untoward or unfavorable symptom, as a result of this procedure, argues most forcibly and cogently for its ulterior recognition and more general use.

ON HYPERTROPHY OF THE LEFT VENTRICLE IN PLAIN STENOSIS OF THE MITRAL.

By Dr. Cosimo Noto, New Orleans.

We can find three modifications of the heart, in the necroposy of one who dies of plain stenosis of the mitral. The heart is atrophic, but most of the time normal, or hypertrophic.

It will seem strange that I put among the modifications of the heart the normal condition of the left ventricle, as no man of the medical art, so far as I know, has attracted attention to this, as I would call it, pseudo-normality.

Hence every one has thought that when the left ventricle is normal in the above disease, it is because it has never been modified.

Now, as I quite differ from this opinion, and as I consider this normality not physiologic (as I will endeavor to prove) I dare say that we can find three modifications of the heart in the necropsy of one who dies of plain stenosis of the mitral.

There being no difference of view among the authors about the atrophy of the left ventricle, it is useless here to speak of it.

Different opinions and consequently various theories have arisen to explain the hypertrophy, which in some cases has been undoubtedly found existent, especially by Baumbach, Luzzatto, Rummo, Lenhartz and Giuffré.

A first theory given to explain the presence of the hypertrophy was that admitting a precedent insufficiency which ceased afterwards.

But to this theory Baumbach justly objected that it was unlikely that an hypertrophy caused by insufficiency could be said to remain unvaried after the cessation of the same and the formation of the stenosis. On the contrary, for this reason the work of the left ventricle being diminished, the hypertrophy should soon disappear and should give place to the atrophy, according to the above theory.

This theory having failed, others admitted the existence of some other complications equally possible, as the insufficiency of the mitral, of producing the hypertrophy of the left ventricle, independently of the plain stenosis of the mitral, that is, the stenosis of the aorta, the muscular efforts, the nephritis, etc.

But it is a well established fact that often the hypertrophy has been observed without the existence of any of those complications.

As to what concerns the aorta, it is true that the quantity of the blood which is in it and in the left ventricle is reduced because of the stenosis of the mitral; but this diminution and the following reduction of the arterial canal never comes to the point of establishing a true stenosis, and such as determining the hypertrophy of the left ventricle. Even as it must adapt itself to the diminution of the mass of the blood, *i. e.*, restrains itself, canalizes itself, so that we must have the concentric atrophy and not the hypertrophy, as Professor Baccelli says.

Neither can we accept the hypothesis according to which the stenosis of the aorta should be connected with conditions of similar nature to those of the stenosis of the mitral.

So much more that the analogic stenosis of the aorta which we can have in chlorosis does not determine the hypertrophy of the ventricle as Professor Luzzato rightly says:

The same may be said of the theory given by Friedreich, that the condition causing the hypertrophy consists in the obstacle opposed to the arterial circulation by the stasis which, because of the stenosis of the mitral, we have in the venous and capillary system. On the contrary, it is remarkable that the left ventricle is not at all hypertrophic in patients who have this stasis and dropsy too pronounced.

As we put aside all these hypothesis, there is the theory of Strumpel.

He says that the left auricle and the right ventricle become so hypertrophic that they can compensate not only the effects of the stenosis of the mitral, but moreover can push into the left ventricle during the diastole such a quantity of blood and with such an increasing pressure that it is forced to work with more activity.

This theory was accepted by Cardarelli, Lenhartz and Baumbach; and they also admitted, but for a very small part, the influence of the energy which is in the muscles of the heart. Besides Luzzatto, Lenhartz, and Baumbach have made mention of a last agent of which Professor Guiffré spoke at length in a communication to the fifth congress of the "Societá Italiana di Medicina interna," that is the diastolic effort that the left ventricle must make because of the stenosis of the mitral to suck into its cavity the normal volume of blood; voicing in favor of this theory the doctrine of the physiologic activity of the diastole, according to which the diastole is not a passive phenomenon only but also more or less active almost as the systole; for this reason if an obstacle intervenes the function of this activity for outdoing it, the diastolic activity must augment its efforts, and so there is a diastolic hyperfunction of the left ventricle and afterwards the hypertrophy of it almost in the same way; as for an obstacle of the arterial system we have a systolic hyperfunction and a successive hypertrophy. Finally, we have Rummo's theory.

"When we have stenosis of the mitral," says he, "the left ventricle has a small quantity of blood, consequently a small quantity of blood goes through the arterial system. It is a law in physi-

ology that the capillaries react upon the blood in a small quantity by shrinking, and for this reason the resistence increases on the periphery, and the left ventricle is forced to work more actively, for sending through the small quantity of blood it has therefore become hypertrophic."

Now, all these theories I have enumerated, whether considered singly or collectively, fall down before one capital objection.

It is a well known axiom that the same causes always produce the same effects.

Now, I ask myself, why this hypertrophy is seldom observed, while in every one of such patients, the same mechanism must exist as above mentioned. That is what is not easy to understand. All these theories, as they seem to me, explain nothing but the mechanism with which the left ventricle becomes hypertrophic; but not one explains why in plain stenosis of the mitral, the left ventricle is very often atrophic, sometimes normal, and very seldom hypertrophic. Now let me be permitted to give my modest hypothesis about it, according to which we can easily explain why the left ventricle in plain stenosis of the mitral is very often atrophic, sometimes normal and very seldom hypertrophic. I think that when the stenosis of the mitral is beginning, the left ventricle must react in its contractions as well in force as in number, and for the above theories of Professor Giuffré, as well as of Professor Rummo, the left ventricle becomes hypertrophic; and it is apt to occur in every patient with stenosis of the mitral during the first period of the disease.

But as stenosis of the mitral is a very chronic disease (it being possible for the patient to live even for fifteen years and more, when other complications do not interfere, and if the patient follows an hygenic regimen), after a certain period more or less long, because the quantity of the blood going to the left ventricle is not sufficient to nourish it in case much more work than it is obliged to do, as well as for other causes, then there is a period of regression and from hypertrophy it must gradually reach a period of marked atrophy.

Now from hypertrophy to atrophy, there is a period in which the left ventricle will have necessarily a volume similar to the normal (a period that I would call preatrophic). And now we see why the normality of the left ventricle is not always physiologic.

My hypothesis is perfectly connected with the hypothesis given by Erb on general distrophies. He says that hypertrophy constitutes the first period of the alteration of the fibres, and after from the same is derived the atrophy.

This hypothesis of course should be proved, and if the theory be exact we can profit in the prognosis and the duration of disease; as the hypertrophy of the left ventricle would denote the first period; the normal volume with the help of the anamnesis the second period, and finally the atrophy should prove the third period which one might confirm with a very careful percussion.

Clinical Report.

A CASE OF LABOR WITH TRIPLETS.

By T. B. ODOM, M. D., French Settlement, La.

In reporting this case it is not our intention to set forth any unusual management but to report a somewhat unusual case managed with good results.

History.—Mrs. Theresa C. White, age 19 years, primipara, weight 110 (nom.), spare built and delicate. Was called to see her on January 9, 1900; then threatened with an abortion and having considerable hemorrhage. Patient was placed in the horizontal position, given full doses of opiates till symptoms improved, then followed up with viburnum prunifolium in doses ranging from 40 to 60 drops, directed to be given 2 or 3 hours as is necessary to control pain. Kept quiet in bed for several days. As patient lived some distance from our place, explicit instructions were given in regard to general management and to repeat the treatment, if at any time threatening symptoms should return. Patient had several slight hemorrhages during a few following weeks, which was controlled at the first; then got along well till August 13, when we were called to attend her in labor. On arriving found labor advanced to the second stage with head presentation. Abdomen greatly distended, as presentation was normal and labor progressing fairly well. We did not make careful exploration of abdominal region. At 2 o'clock P. M., patient was delivered of a girl weighing 5¼

pounds, in 40 minutes afterwards was delivered of a boy weighing 6¼ pounds, then just 20 minutes later was delivered of another boy weighing 4¾ pounds. In about half hour later was delivered of two placentæ intact except a small amount of membrane or capsule. A third and smaller placenta was then detached by its fingers from the fundus-uteri in piecemeal and subsequently by irrigation.

During the first twenty-four hours following patient had an abnormal temperature running as high as 102½ deg., then gradually subsiding.

Patient made an uninterrupted recovery; is now doing her household work and nourishing her three babies by the breast and artificially alternately.

Weight of babies to date (Feb. 5, 1901) respectively 12, 14 and 15 pounds, and have been healthy, except all just recovering from scarlet fever.

Charity Hospital Notes.

A CASE OF FIBRINOUS PLEURISY.

FROM MEDICAL CLINIC OF DR. JNO. B. ELLIOTT, PROFESSOR ON GENERAL AND CLINICAL MEDICINE, MEDICAL DEPARTMENT, TULANE UNIVERSITY, NEW ORLEANS, La.

We present a case of fibrinous pleurisy in a man aged 35; a laborer by occupation, single, and native of New Orleans. His family history is negative. The account of the present attack is that he, while at work, caught cold, which in turn was followed by some fever and rapid pulse and pain in the side. Examination revealed some dullness upon percussion, friction sounds, with some slightly increased fremitus and expectoration. He evidently had a slight attack of bronchitis also. There are three forms of pleurisy, viz.: Fibrinous, in which there is simply a local inflammation of the pleura with more or less fibrinous exudation; sero-fibrinous, with sero-fibrous exudation into the pleural cavities; chronic pleurisy. Hydrothorax is really not an affection of the pleura, as the liquid does not accumulate in the pleural cavities as a result of any local affection of the pleura, but results from some circulatory defect, nephritis or

any disorder which would favor serous effusion in general, struma, etc.

The sero-fibrinous form is also indicative of some other systemic failure, and its presence should always arouse suspicion of the strumous diathesis. If the sero-fibrinous effusion be submitted to bacteriologic examination, the pneumococcus will be quite frequently detected, while in the effusion of chronic pleurisy various micro-organisms are usually present. If the effusion of pleurisy be found sterile we are likely dealing with a tubercular condition. A peculiar fact noted in this connection is that staphylococci and streptococci are sometimes found in these effusions without the production of pus. It is probable that these germs do not here produce pus, because atmospheric air is excluded. In regard to physical examination in pleuritic cases, as much as 8, 10 or 12 ounces of fluid may be present in the cavity without its being detected—there is not enough to produce physical signs. It is a well known fact that the upper line of dullness produced by fluid in the pleural sacs is not a straight horizontal line. This is not a violation of the law of hydrostatics. It is due to the fact that some portions of lung tissue are more elastic than others and consequently there is unequal resistance to the pressure of the liquid with the result that the upper limit of the effusion is a more or less curved line.

Returning to the dry or fibrinous form which we have here: Normally the pleural membrane secretes just enough serous fluid to keep the surface fairly moist, the object of which is to reduce friction to a minimum, and the pleural surfaces glide up and down upon each other noiselessly and without pain or even consciousness of the subject. In dry pleurisy the exudate roughens the contiguous surfaces. Now upon the surfaces being dragged to and fro by respiration there is produced a friction sound which is characteristic and the cardinal physical sign of dry pleurisy. It may be simulated by placing the palm of one hand over the ear and rubbing the fingers of the other across it. This sound, of course, varies in intensity and quality according to the extent of the exudate. The inflammation present is the cause of a hypersensitiveness, hence the pain produced as the surface are moved in respiration. There is also increased friction added to the hypersensitive condition. After this inflammatory process

has gone on for time the exudate becomes organized, and we have thickened pleuræ, varying in extent as the attack is intense or of long duration. The physical signs of this thickness are decreased fremitus, decreased voice sound, dullness on percussion, respiratory mumur decreased or absent. During this process of organization of the exudate strings of fibrinous material reaching from one surface to the other may become organized.

Of course large areas of the pleural surfaces may, and frequently do, become adherent under this inflammatory process, and remain bound together, constituting a most serious sequence of the disease. Bearing in mind the foregoing briefly summarized facts, it becomes apparent that our treatment of these cases must be directed (1) at allaying the inflammation in progress. A common mustard plaster is very effective in accomplishing this. Another method, though of domestic origin, is to take equal parts of black pepper and flour made into poultice and applied to the skin over affected area; the black pepper doesn't irritate, or even redden the skin; (2) relieving pain, if excessive and intolerable, by the administration of opium or morphin; (3) opening the bowels with some good cathartic. Calomel will answer this purpose well, as will magnesium or sodium sulphate. Some practice strapping the chest to diminish respiratory movements on the affected side, with a view to giving rest to the inflamed and painful pleuræ.

If a case of pleuritis is seen early enough and the above treatment properly applied, it can generally be aborted, or the attack decidedly lightened and shortened. If, however, under proper treatment, a case of pleurisy resists treatment and continues for some time in a subacute or chronic form, look out for tubercle. In fact, a great many observers are agreed that pleuritic cases in general are only too often of a tubercular character, or at least dependent upon the strumous diathesis for their occurrence. Hospital statistics compiled to bring out this point show that 40 per cent. of cases of sero-fibrinous pleurisy afterward developed tuberculosis. Chronic pleurisy is nearly always tubercular. The rationality of treating a case of chronic or long-standing pleurisy of any form as though we were dealing within a common case of phthisis then becomes apparent.

N. O. Medical and Surgical Journal.

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE EVILS OF ALCOHOL.

The National Woman's Christian Temperance Union have issued an appeal to the physicians of the United States to aid in the efforts being made to remove, as far as possible, all tendencies and temptations toward the formation of the drink habit; also to warn parents against the home prescription of alcohol and the use of proprietary medicines containing alcohol or narcotic drugs. They credit those physicians who allow to alcohol a very limited sphere of usefulness, or none at all, as being their most effective allies, and admit that if the evils of liquor drinking are ever to be fully abated, the medical profession must take a more active part in this much-desired reform.

This appeal, which we have not space to print in full, is clear, logical, and, in our conceit, we were going to say, manly. It is more than all that—it is womanly; but womanly in the best and highest sense; it touches the heart and the sympathies, it is true, yet it appeals as well to the reason and the good sense of the profession. Deeply impressed by the appalling misery of blasted intellects, wrecked bodies, ruined homes and degenerated nations wrought by these potent agents, the good women of this Union turn to us and say: "Some of you are aiding us, but we need you all; we are almost powerless without you; help us."

Shall we not heed the cry? We know they are right. We may differ as to how large or how small an extent of alcohol can serve as a medicine; we may disagree as to the advisability of total abstinence for everybody, but we all agree as to the terrible evils of intemperance and the horribly insidious danger and destructive effects of the various drug habits. We must respond to the call. We know these good women do not exaggerate our influence in the matter. By our researches, by our teachings and our warnings, by our example, we can do more than all other professions or callings put together.

We know more—and, if these good women know it too, they are too politic, or probably too charitable, to utter it—we are often responsible in individual cases for the inception of the alcohol or the drug habit. Many physicians are entirely too careless and reckless in advising the taking of alcoholic drinks as bracers, in prescribing narcotic drugs for minor ailments with the knowledge of the patient, in tolerating the use of tonics (so-called) containing dangerous drugs, to any and all of which the patient may gradually and innocently become addicted.

Reform in these matters is easy. All of us can readily accomplish that. As for the rest, let us study the whole thing impartially. Let us not hesitate to condemn whatever we already know is bad and all that we may with further light find to be injurious. Let us even give the benefit of all doubt to the good cause and assist to the utmost these noble women who are devoting a large part of their lives to a battle with one of the most potent evils of the century.

POST GRADUATE INSTRUCTION.

In running editorial comment of a recent article of Sir Michael Foster, the editor of the *Practitioner*, Dr. Malcolm Norris, offers due criticism of the position taken and mildly protests against the view of Sir Michael Foster that postgraduate schools should be arranged for the purpose of research rather than for practical instruction in current medical matters.

We may be permitted the expression of opinion on both sides and from the standpoint of a country of newer methods than the one in the schools of which Sir Michael Foster gained his qualifications.

The isolation of the vast majority of the practitioners of medicine in the United States, living as they do in provincial towns, villages and country districts with only the education which a few medical periodicals and some few texts bring them, compels the sort of routine which very soon begets lack of information. The science of medicine is making rapid strides and in so many ways that the man who steps aside from the procession is very

apt to get so far behind that it requires decided instruction for him to recover his ground.

It is just this function that the post graduate schools in the United States are fulfilling. In the beginning, our polyclinics were organized simply to provide material for study and competent instructors for recent and older graduates who wanted to see in a practical way the kind of cases they had to meet in their professional work. But the exigencies forced a wider field of instruction, until to-day the modern postgraduate school has the laboratory and other facilities to meet the demand of the times.

That these schools have done good is patent to every one who considers their history. Aside from the fact that New York, Philadelphia, New Orleans and Chicago have well reputed postgraduate schools, the patronage of these from year to year has increased until from every suburban and rural district in the whole land physicians come to the cities for a clinical overhauling, in order to intelligently care for their own patients when they get home. It is just by such method of instruction that to-day the country doctor is familiar with laboratory technic and uses the serums in his practice with the same skill in procedure and with the same satisfactory results as his urban contemporary.

But Sir Michael Foster is right in one respect: The postgraduate school should be endowed and it should have men on its teaching staff whose whole time and sole attention should be given to experimental research, in which the student body could share. This work to-day is done by a few of the undergraduate medical schools and by devotees in large part. Because of the wider needs of postgraduate schools, however, in the demand for more advanced work, we should not be either willing or ready to disparage the broad and great work which the present schools are doing.

Society Proceedings.

ORLEANS PARISH MEDICAL SOCIETY.

MEETING FEBRUARY 9, 1901.

DR. MOSS read a paper on "*A Case of Syphiloma Simulating Osteo-Sarcoma of the Clavicle.*"

The case in question is only interesting in that it points out how careful we should be in making a too hasty diagnosis in bony tumors.

C. J., colored female, age 25, admitted to surgical ward 36, November 22, 1900, suffering from tumor of right clavicle, which was causing her considerable pain. Patient first noticed small lump in January, 1899, but it caused no inconvenience until September, 1900, when it commenced to give pain. All this time tumor had been slowly increasing in size. No syphilitic history; no history of trauma. Upon examination found hard smooth tumor, about the size of an egg, half inch to right of sterno-clavicular junction. Pain radiating from tumor along clavicle and down right arm; no worse at night; greatly increased upon pressure; evidences of syphilis negative; no glandular enlargement; general condition good; diagnosis of osteo-sarcoma suspected. Owing to overcrowded condition of ward, we decided to let patient go home and return in two weeks. Before she left, and after consulting with Dr. Martin, I put her on bichloride, gr. $\frac{1}{24}$; potassium iodide, gr. xv., t. i. d. This was later increased to bichloride, gr. $\frac{1}{16}$; potassium iodide, gr. xv., t. i. d. In two weeks time pain had ceased, and when I last saw patient on January 15, 1901, there was scarcely a trace of the tumor discernable. I now believe the tumor to be a syphilitic exostosis. The moral is—always give the patient the benefit of the doubt in this class of tumors.

DISCUSSION.—DR. SEXTON had had a patient with a bony tumor of the femur, for which amputation had been advised. A history of previous chancre was obtained, and the case did well under iodide.

DR. SEXTON presented a paper on "*Varicocele.*"

Varicocele is the dilatation of the veins of the spermatic cord and of the pampiniform plexus. Perhaps 10 per cent. of young men suffer from this trouble, at least to a limited extent. It is

most commonly met with about the age of puberty, when the sexual passion is most active and usually least satisfied. For this reason many cases of mere dilatation of the veins are cured after marriage. Ninety per cent. of the cases occur on the left side. The first reason being, that the left testicle usually hangs lower than the right. Second, the left spermatic vein empties into the left renal vein at right angles, having no valve to protect the entrance. Third, the sigmoid flexure of the colon lying on the left side, if impacted with feces, presses upon the veins of this side, thus obstructing the return of blood.

Symptoms.—The varicose condition is of gradual growth. They are often discovered by accident, before any subjective symptoms appear, but sooner or later the patient experiences a dull heavy pain in the back, groin and testicles, which pain is aggravated by any sexual excitement or bodily fatigue. The average young man in this condition usually becomes a sexual hypochondriac, particularly if he has been reading up the quack literature of the "know thyself" order, gotten up by the genito-urinary "fakist," and scattered throughout the country. This varicose condition is most commonly found in young men with a lax and pendulous scrotum, particularly if the subject is addicted to masturbation. Improperly fitted trusses obstructing the venous return of blood is not an infrequent source of this trouble.

Diagnosis.—Omental hernia is about the only condition resembling varicocele. The distinction between the two is easily made by placing the patient in the recumbent posture when the enlargement from both causes disappears, but if the finger is placed firmly over the inguinal canal, thus preventing the omentum from protruding, and the patient is made to stand up, the varicocele immediately refills itself; but to the practiced touch the worm-like feel of varicose veins can hardly be mistaken for any other condition. The enlargement is pyramidal in shape, a soft, irregular swelling in the scrotum, the principal portion of the mass of veins usually being below, but slighlty overlying the testicles. These dilated and tortuous veins are easily distinguished through the skin. Upon coughing there is a distinct impulse. On lying down the swelling almost disappears. Upon assuming the upright posture with pressure over the external abdominal ring, the veins soon refill from

below upwards. The testicle on the affected side is usually soft and tender, subject to neuralgia, and in time may become atrophied. Seminal emissions or wet dreams are quite frequent in young men suffering from varicocele. The mental despondence and hypochondriasis common in these cases is one of the principal reasons for some radical procedure to get rid of the trouble.

The palliative treatment consists of frequent cold astringent bathing of the part.

Keeping the bowels open and regular, avoidance of ungratified sexual appetite and the wearing of well-fitting suspensory bandage. But more radical measures are called for when there is much pain in the testicles and groin, and later on when atrophy is threatened, or the hypochondriac state is pronounced. Of the radical procedures recommended may be mentioned the subcutaneous ligation of the dilated veins, notably Keyes' method, and the open ligation and excision of the veins, which is much the most preferable operation. The ordinary technic of the operation is, after thoroughly shaving and scrubbing the parts and hooding the penis, and either giving a general anesthetic or injecting about two drachms of a one per cent. solution of cocain into the soft parts over the veins, an incision about two inches long, beginning just below the external abdominal ring, extending downward over the varicose tumor for two inches, is made by transfixing the parts; after a careful blunt dissection the veins are lifted to the wound and the vas deferens is recognizable, a hard cord, and with its vein and artery is to be held carefully away from the bunch of veins which are to be removed. For the return of venous blood from the testicle it is often best to leave one or two veins untied. It is also important that the veins must be tied at the bottom as well as at the top of the scrotum. To neglect this has often failed to cure the varicocele, the veins filing from below leaving a large mass of vessels around the testicle to be filled with blood. After the large trunks of the veins have been carefully isolated a ligature is applied around them below the external abdominal ring and at the lower portion of the varicocele, the dissection reaching down nearly to the epididymis. The lower end of the veins are secured by two ligatures, when the section of veins between are divided by scissors and removed. One

end of each ligature is usually left long and the two stumps of veins are by these long limbs brought up and secured to each other, which procedure takes some of the slack out of the pendulous scrotum. Care should always be taken not to pull the ligatures off the stump in bringing the divided ends together. Another method of getting rid of a portion of the pendulous scrotum is to stretch the cut so as to sew up the incision transversely instead of longitudinally. After carefully arresting all bleeding points the incision can usually be closed by continuous suture, dusting the wound with some antiseptic powder, covered by a collodion and cotton dressing, applying a suspensory bandage, and the proceeding is finished.

It is usually well to support the scrotum with a well fitting suspensory bandage, well padded with cotton. In very irritable subjects it sometimes requires the use of catheter two or three times on account of a stammering bladder, but this is not the rule, but the exception. A week or ten days in bed usually completes the cure, but the convalescent patient must wear his suspensory bandage and avoid violent exercise for months after the operation has been performed, and even with this precaution the testicle remains enlarged and tender for months after patient is discharged.

Discussion: Dr. Gessner was opposed to marriage for relief of sexual neurasthenia. Cold water is beneficial in incipient varicocele. Suspensory inadvisable save in pronounced cases, because laxity of the cremaster may be increased if that muscle be relieved of its normal function. Subcutaneous ligation is a relic of the pre-listerian period. A one-fifth per cent. cocain solution usually suffices when injected by Schleich's method. Dr. Gessner had seen a case sometime after the usual open operation for varicocele, in which the tranverse suture of a longitudinal incision had failed to permanently shorten the scrotum. Reported three cases of varicocele as follows: 1st case—Negro, age 40, married, several children. Very little bleeding during the operation, and no ligatures used. Wound subsequently reopened because of troublesome and persistent hemorrhage. Patient afterwards gave history of hemorrhagic diathesis. 2nd case—Tunica was opened accidentally, but was sutured with satisfactory result. 3rd case—Young man, neurasthenic. Of neurotic family history. Patient had large left varicocele, which

PROPERTY OF
N O POLYCLINIC
DO NOT TAKE OUT

didn't seem to give any trouble. Suspensory seemed to be all that was needed to keep patient comfortable. Dr. Gessner had not decided whether the case called for operation, especially as he had in mind a case of double varicocele in a man who presented absolutely no neurasthenic stigmata.

Dr. Perkins also opposed to advising sexual neurasthenics to marry. Had examined results after various subcutaneous operations on the cadaver many times in the last few years, and was impressed with the dangers of all subcutaneous procedures. Itching of scrotum a very frequent accompaniment of varicocele. Cold water of undoubted benefit in some cases. In preparing for scrotal operations, the use of alcohol or irritating solutions of any kind must be avoided. Local analgesia usually sufficient. Of course some veins must be left. Cat-gut should be used very freely as it was never safe to trust compression or torsion in this region. After resection of the selected veins the stumps should be approximated at 4 points, using the long ends of the two principal ligatures, and 3 stitches at equal distances around the circumference of the stumps. Some enlargement and tenderness of testicles might persist sometimes. A collodion dressing might be used, or a few layers of sterile gauze and cotton might be held in place by a suspensory. If a suspensory were carefully adjusted, the patient need not remain in bed more than a few hours.

Dr. Martin operated whenever there was a tendency to enlarge. Ligated all vessels because it was impossible to make effective pressure on scrotum for post-operative bleeding. Cat-gut preferred. Hemostasis especially important, as hemorrhage made infection likely. Operation should be as dry as possible. Agreed with Dr. Gessner that closing the wound at right angles to the line of incision did not permanently shorten the scrotum. Local analgesia always sufficient.

Dr. Sexton, in closing the discussion, said that he must not be understood to recommend marriage simply to cure a varicocele, but some small varicoceles undoubtedly improved after matrimony. The method of shortening the scrotum did do good temporarily, at least.

Dr. Nelken read a paper on "*A Peculiar Case of La Grippe.*"

"Influenza is a disease which manifests itself in so many different forms that, during the prevalence of an epidemic, it be-

comes often, to say the least, a diagnosis of convenience. This is especially true in those conditions where we are forced by the peculiarity of the symptoms to arrive at a diagnosis by exclusion.

"In spite of that fact I do not think there can be any question that the following case is correctly reported as one of La Grippe:

B. K., white male, age 30, merchant. He awoke in the morning with feeling of malaise, and says the glands at angle of right jaw were swollen and painful. However, he went to his business, but was compelled to return home about mid-day and to go to bed. He had several slight chills, headache, pains in the limbs, and a severe spell of vomiting. Pain in neck, which was marked on pressure, had extended to clavicle and the glands on the left side were also swollen and painful.

"When I was called to see case, temp. was 101 deg. F., patient was in considerable pain and I could readily feel the enlarged and tender lymphatics of the neck. Phenacetin and codeia relieved pain to a great extent, but next day he still complained of soreness in neck and also said that chest just under sternum was painful. That night, temp. rose to 103 deg. F. Next day, he was better except for the pain under sternum which was worse. Examination of lungs showed nothing abnormal.

"He contiuued to complain of pain in chest, saying it felt like a lot of boils and hurt everytime his heart would beat. A mustard poultice was applied and gave little relief. The hot water bag was somewhat more successful, and this, together with the administration of codeia and phenacetin, permitted him to fall asleep towards night.

"That night patient told me he awoke suddenly with severe throbbing pain in chest. He is in no sense an hysterical subject but said that pain was so severe that it was only by the exercise of great self control that he could avoid shrieking every time his heart would beat. After some time this feeling abated, and with the help of his medicine he was able to go to sleep again. Next day he was feeling better, but testified to a dread that the pains of the previous night would recur. However, he continued to improve, and in a couple of days was well. The glands of the neck are now of normal size.

"I explain this rather peculiar condition by supposing that the

inflammation of the glands of the neck had spread to the lymphatics of the thorax, and the severe throbbing pain was due to the pulsation of the great vessels of the chest, pressing against the inflamed lymphatic glands of the anterior mediastinum.

There was no evidence of involvement of other lymphatics of the body and no lung complication."

DISCUSSION.—DR. LEBEUF had seen many cases characterized by neuralgic pains all over the body. A prescription containing quinin, caffein citrate, Dover's powders and phenacetin was often beneficial in the acute stages.

DR. STORCK prescribed strychnin three or four times daily in large doses, sometimes gr. $\frac{1}{15}$. Had found this to relieve cough. Monobromate of camphor in 1 gr. doses also beneficial.

DR. BARNETT had found in his own case that grippe cough was paroxysmal and not easily suppressed. Pains in head a prominent and annoying symptom. Heroin, gr. $\frac{1}{16}$ at a dose, without influence on the cough. Ipecac in the Dover's powders increased the nausea so frequently present. Petroleum given in form of emulsion, and allowed to trickle slowly down the fauces, relieved the cough. In one of Dr. Barnett's cases hypodermics of cocain had no effect in controlling the extreme nausea, which yielded, however, to anti-emetics and ice-bag. Considered grippe a self-limited and very rebellious disease, which was little effected by remedies.

DR. PERKINS considered that the pains of grippe could be quickly relieved by various combinations of phenacetin, salol, quinin and caffein citrate. Used strychnin every three of four hours, in doses of gr. 1-30 to gr. 1-20. Insisted upon the advisability of keeping the patient warm and comfortable. Considered a few days in a warm room of great value in treating grippe.

DR. MAINEGRA: Type this year mild. Ipecac liable to cause troublesome emesis. For cough advised a combination of spts. mindererus, spts. nitre, syr. senega and syr. wild cherry, to which may be added codein or Battley's sedative.

DR. DABNEY regretted the substitution in recent years of sugar of milk for the potassium sulphate, as the later Dover's powders were more nauseating than those made by the old formula. One-half gr. of ipecac given alone would not nauseate. Often gave 3 or 4 grs. of ipecac three or four times daily. Had one

patient who, though taking 12 grs. of ipecac daily, was nauseated by one-half gr. in Dover's powder. Considered the milk sugar the main cause of nausea from Dover's powders.

Dr. Gessner, referring to cough in grippe and other diseases, had found heroin hydrochloride given in $\frac{1}{10}$ gr. tablets of no value in 3 tuberculosis cases.

Dr. Storck has seen $\frac{1}{12}$ gr. of heroin cause dizziness and staggering.

Dr. Barnett had found heroin better than codein in tuberculous cough, and followed by no unpleasant after effects.

Dr. Gessner had noticed marked drowsiness in a patient taking $\frac{1}{10}$ gr. of heroin every 2 hours.

Dr. E. J. Huhner had seen sleep quickly induced by $\frac{1}{15}$ gr. of heroin, but after effects similar to those of morphin followed. Considered codein and tr. hyoscyanus a good combination for grippe cough. Heroin had usually failed in his hands.

Dr. King had found that after a few doses the effect of heroin was usually lost, and opium symptoms were often produced.

Dr. Nelken, closing the discussion, had found heroin of little value in tuberculous cough. Preferred codein with dil. hydrocyanic acid. Dover's powders usually unreliable. Thought that the anti-rheumatic remedies, especially the salicylates, promised well in grippe.

Dr. Barnett reported *a case of obstipation in a young mother* upon whom he had tried all the usual drugs. Six lapactic pills had failed to cause an evacuation, and fluid ext. of cascara, ℥ss. t. i. d. had also failed. Without medication patient would have no bowel movements for 10 or 14 days, and then would pass only 2 or 3 scybalæ. When bowels do move, patient is in great pain for an entire day. Her other functions seem normal, but she appears rather poorly nourished.

Dr. LeBeuf mentioned the possibility of intestinal paresis, suggested the use of nux vomica and enemata.

Dr. Storck suggested high olive oil enemata, massage roller and electricity.

Dr. Gessner mentioned cannon-ball massage, familiar to former pupils of Dr. Chaillé, and inquired if digital rectal examinations had been made.

Dr. Barnett had been unable to obtain any additional information by digital examination.

Dr. Nelken: Some authorities had made a distinction between obstipation and constipation, limiting the former to conditions due to mechanical obstruction, as for instance, by the valves, whose existence Mathews denies.

Dr. Mainegra: In an obstinate case massage had done good.

Dr. Dabney recently found rectal stricture in a lady 75 years old, who had been for a long time treated for constipation. Nux vomica and large enemata of Glauber's salts of use in some cases. Examination with rectal speculum always advisable.

Dr. Perkins: A hospital patient, apparently insane, had claimed to have had but one evacuation in 50 days, going 25 days at a time without bowel movement. A large, doughy mass was felt in sigmoid, and scooping enemata removed large quantities of feces from rectum. Patient escaped before sigmoid was emptied. Had seen a patient treated alternately for hysteria and constipation, with no evacuation for a week or two, in whose ascending colon a malignant stricture was found when laparotomy was finally performed. "High enemata," so often alluded to, so often referred to in medical literature, were often farces, as the distal end of the rectal tube could usually be found just above the sphincter. Had experimented on chloroformed dogs, tapping exposed intestines sharply with small rods, and the peristaltic movements followed immediately. Clinically, was in the habit of using massage for colic, preferring percussion and kneading to other forms. As to Dr. Barnett's patient, she might be one of those physical freaks whose normal intervals between evacuations were very long. The main point in diagnosis to be cleared up was whether very little fecal matter was actually accumulating, or whether a normal amount of feces was being pent up in the intestines.

Dr. Gessner, in using rectal tubes for cholera infantum in children, had found difficulty overcome by introducing tube while water flowed through it. Rectal strictures more common than ordinarily suspected. Massage useful. Lying on back and raising lower limbs an excellent measure in overcoming habitual constipation.

Dr. Martin: Horse catheters were sometimes useful where rectal tubes proved insufficiently rigid.

Dr. Barnett, closing discussion, said he had been misunderstood. The apparent almost total absorption of food ingested was the interesting feature of the case. No deformity of the rectum save two internal hemorrhoids. Uterus small and retroverted, but readily replaced and held by pessary. Had made rectal examination and had tried irrigation. Knew it was difficult to pass rectal tubes. Had once tried for two and a half hours in a case of intestinal obstruction. In babies it was an easier matter. In Charity Hospital saw a laparotomy after a rectal tube had been introduced and left in situ as a preliminary measure. The tube was found to be coiled in the sigmoid flexure. In the case he reported, ten or fourteen days was probably the normal period between evacuations.

Dr. Storck suggested lamp-black, given in capsules, to determine rapidity of fecal movement.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans

Effect Produced on the Circulation of the Dog by the Intra-spinal Injection of Cocain.—Mr. Hallion and Tuffier, in *Semaine Médicale*, November 7, 1900, state that they studied by a suitable technic the effect produced on the circulation of the dog by the intra-spinal injection of cocain. Whilst this alkaloid, introduced into the blood vessels or into the cellular tissues, raises the pressure and produces a general vasoconstriction, the subarachnoid injection of cocain in the lumbar region always causes a lowering of arterial tension, which follows a vasomotor paralysis of the whole sub-diaphragmatic tract and due itself to paralysis of the intra-spinal nervous elements directly influenced by the cocain. The arterial tension can always be again brought to its original pressure, either by exciting the splanchnic nerves which cause a well marked vaso

constriction in the previously paralyzed zones, or by compressing the abdomen.

Analgesia Produced by Subcutaneous Injections of Peroxide of Hydrogen.—Dr. H. E. Kendall, of South Sydney, in *Semaine Médicale*, November 7, 1900, states that a local anesthesia sufficient to perform minor operations can be induced by the hypodermic injections of oxygenated water. By this means he was enabled to incise abscesses, and even open the pleura and peritoneum without pain to the patient.

The analgesic effect of peroxide of hydrogen is not due to the absorption of the injected liquid as one would suppose, but to the tension caused by the abundant liberation of the gas in the subcutaneous cellular tissue, the injected zone becoming as hard as frozen tissue.

Tetanus after a Vaginofixation.—Menzer gave notes (at a meeting of the *Gesellschaft der Charite-Aerzte* in Berlin) on a case of tetanus after a gynecologic operation. A vaginofixation, notwithstanding most careful preliminary and operative antisepsis, was followed in seven days by a fatal tetanus. In the secretion of the wound the bacilli of tetanus were abundant. Blumenthal, discussing the subject, advocated the regular injection of anti-tetanic blood-serum before every operation upon the female genitals. In the French colonial forces such prophylactic procedure among the wounded had proved very efficacious. Jacob added that dural infusion is better than the subcutaneous. —German Letter of the *Medical News*.

Serum Mystery in Milan.—A curious case of poisonous serum is reported from Milan. Eight persons suffering from diphtheria died of tetanus after having undergone the orrhotherapic treatment. The authorities immediately closed the institute and prohibited the use of the serum throughout all Italy, pending an investigation by the health board of Milan and the council of hygiene in Rome. The directors of the institute in Milan called in all the flasks of the serum which it had sent out, and destroyed all the materials for the different serums in process of preparation. The case puzzles the professors. They don't know yet whether the serum was contaminated by the presence of the microbes of tetanus or whether by some unfortunate accident anti-tetanic serum was used in the diphtheria cases with fatal effect.—*New York Medical Record.*

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans.

The Present Status of the Treatment of Puerperal Infection.—*The Medical Record* (January, 1901), contains an extensive extract of an article by Dr. Henry Garrigues on the above subject, from which the following points are gleaned:

Injections.—Intra uterine injections demand a certain amount of skill not found in every legally qualified practitioner. He had seen cases in which injections had caused a rise of temperature, and the patients had recovered after the injections had been stopped. There was always danger of poisoning when corrosive sublimate solutions were used. He had collected twenty-three cases of death attributable to the use of corrosive sublimate. At the beginning of the attack injections after curetting were useful.

Cauterization.—Where the wounds become diphtheritic he applies a caustic composed of equal parts of zinc chloride and water. Vaginal injections should be given every three hours, and the parts examined daily with a speculum, and if the diphtheritic processes spread further, cauterization should be repeated. He preferred zinc chloride applications to all other in such conditions.

Aperient Enemeta.—At the beginning of puerperal infection the bowels should be thoroughly cleared out. When peritonitis existed, he did not move the bowels except by occasional enemeta, preferably soap suds and ox gall.

Anodynes.—Pain was relieved by opiate, local or internal when necessary. To reduce temperature the local application of cold was best. Ice coils were convenient. If the interior of the uterus was infected suppositories of iodoform were introduced into the cavity daily. Iodoform gauze was good for packing, but not for drainage. In absence of uterine contraction, ergot by mouth and faradization of the uterus was indicated.

Internal Antiseptics.—If the patient has been exposed to diphtheria, give diphtheria antitoxin. Anti-streptococcus serum has

apparently been proved not only useless, but harmful. He had not personally seen any good results from unguentum Credé. Howevever, it was at least harmless. A rational and useful modern method of combating sepsis was washing out the whole system by the injection into the veins of one or two pints of saline solution at short intervals. When vomiting was a prominent feature cocain, hydrocyanic acid or ice coils to the epigastrium were indicated.

Curettage.—If there is doubt about the placenta having been totally removed, the patient should be anesthetized and a systematic digital exploration of the cavity made, special attention being paid to the horns of the uterus. Any remains should be scraped away with the finger nails, a far better method than using instruments. He did not think he had ever seen a patient recover when curettage had been resorted to after sepsis had become well established. He had found the curette a well nigh indispensable instrument in cases of abortion.

Abscesses.—Where an abscess pointed above Poupart's ligament, a large incision should be made parallel to this ligament. Then the finger should be introduced, and if necessary, thorough drainage established by way of the vagina. If an abscess could be reached easily through the vagina it was better to make a transverse incision behind the cervix and drain. If the latter were situated in the broad ligament it could be opened without entering the peritoneal cavity.

Laparotomy—Whoever had seen an autopsy on a person dead of diffuse peritonitis must feel timid about opening the abdominal cavity during life. Since the uterus was the starting point (usually) gynecologists had been inclined to remove it, but to be of service this operation must be done before the general system was invaded. It was difficult to determine this, hence the operation was liable to be done too early and too late. In the hands of men of exceptional judgment and skill a few lives would be occasionally saved, but the average practitioner would best subserve the interests of his patients by abstaining from even such seemingly simple operations as intra-uterine injections and curettage.

Pregnancy Complicating Carcinoma of the Cervix—Cullen (Cancer of the Uterus, page 611) states that the

occurence of pregnancy during the course of carcinoma of the cervix, although not common, is no great rarity. The patient will come complaining of the usual bloody or watery discharge. If the carcinoma be first detected the pregnancy may be overlooked, since the free hemorrhages may be mistaken for a disordered menstrual flow. The loss of blood is often exceptionally severe in these cases on account of the extreme vascularity of the uterus. In 29 per cent. of Cohnstein's cases the women either aborted or miscarried. From the pregnancies going to term 36 per cent. of the children were born alive. Pregnancy may go on to term and labor come on in the usual way without any untoward symptoms. In some cases, however, the most disastrous results may follow. Deep tears may take place into the hard but friable carcinomatous tissues, so that the bladder or rectum is opened. At another time the whole carcinomatous tumor may be torn off and expelled through the vulva. Rupture of the uterus has been frequently reported. Hermann found reports of 11 ruptures in 180 cases and Cohnstein cited 14 cases in which women died undelivered. Of these pregnancies 13 were at term, 1 in the seventh month. The patient may pass term without delivery.

Treatment.—Wherever a carcinoma occurs during pregnancy, the radical operation, if possible, is to be performed at once, and must not be delayed in order to afford a chance of life to the child. All are agreed that during the early months operation should be performed immediately, but where the woman is in good condition and the child is within a month or two of viability, the operator is sometimes prevailed upon to wait. The inclination to yield to these considerations and to delay is rapidly disappearing. The tissues are much more vascular, and and under such favorable condition the neoplasm makes rapid progress, and according to Davis, still more rapidly during the puerperal condition.

Vaginal hysterectomy is the method which promises the best results in carcinoma of the cervix when operative interference is instituted during the early months of the pregnancy. Most operators think that after the third month of pregnancy the uterus should be removed per abdomen, but others have performed vaginal hysterectomy as late as the fifth month. After this time Cesarian section and abdominal hysterectomy are

recommended. In hopeless cases we can only look to the comfort of the mother and wait till the child comes to term.

Just before labor commences, the growth may as far as possible be curetted away; then as soon as labor has started, stellate incisions should be made in the cervix, after which labor may terminate in the usual way, or the application of forceps may be necessary. Turning may be necessary but it has been shown to be quite dangerous. Perforation may be done if the child be dead and the head large. Here, also, the mortality is great to the mother. From the above it is seen at best that delivery by the vaginal route is very dangerous. When the child is viable Cesarean section seems to offer fairly good results. Cesarean section followed by the Porro operation is the procedure to be recommended. In all instances one must be prepared for infection.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Treatment of Biliary or Hepatic Colic.—For a case of an impacted gall-stone giving rise to acute symptoms, known as hepatic colic, the following course is briefly the best to follow, in general. If called when the colic is just beginning prescribe:

Amyl valerianate	Three drops
Sulphuric ether	Four drops

In one gelatin capsule.

Give six capsules, two at a dose every half hour.

If not successful in relieving pain with this, or if called when the colic is well started, give at once a hypodermic of morphin and cover the painful area with a hot poultice of large size, sprinkled with laudanum.

Order also:

Saturated chloroform water	fℨ vi.
Distilled water	fℨ iv.
Syrup of orange flowers	fℨ ii

Sig.—One tablespoonful every ½ hour until completely relieved.

If this is not retained give it with cracked ice.

If vomiting is persistent order champagne and the following two solutions, A. and B.

A.

Potassium bicarbonate ..... ℥ ss
Distilled water ..... fl℥ ii

B.

Citric acid ..... ℥ ss
Distilled water ..... fl℥ ii

S: One tablespoonful of A to be followed immediately by one tablespoonful of B as often as necessary to check vomiting. Should the attack persist after the acute stage is over it is claimed by some that five to eight ounces of olive oil given at one dose with a few drops of anise oil will bring about a complete relief. It may, indeed, have a soothing effect on the irritated gastro-duodenal mucous membrane. But others deny that the olive oil lubricates the bile passages for the stone to pass. When tolerated and taken for a number of days in succession it produces fatty concretions in the stools, resembling biliary calculi and which are mistaken for biliary calculi.

If the oil treatment is not acceptable to the patient's stomach try from four to six drachms of glycerin in vichy water, to be repeated every day until the attack is completely over. Neither a purgative at the beginning of the colic nor a bath during the attack should be given.

The olive oil and glycerin may be considered as useful cholagogues and cathartics after the acute pain is relieved by the hypodermic of morphin. As to the feeding of the patient during his illness it should consist of iced milk and cold broth; as to drinks, vichy water and seltzer water lemonade are the best. But food and drink must be given in very small quantity and in short intervals.—P. A. Mesnard, M. D., *Presse Médicale.—L'Union Médicale du Canada*, December, 1900.

On the Early Diagnosis of Pulmonary Tubeculosis.—Weicker, of Görbersdorf, writes an appreciative review of Knopf's paper on the early recognition of tuberculosis (which was read last year before the New York County Medical Asso-

ciation) for the *Deutsche Aertzte-Zeitung*, Aug. 1, and 15, 1900. His comments and addenda are of interest. He agrees with Knopf that the solution of the problem as to whether or not tuberculosis exists in a given case has not been brought about by Koch's discovery of the bacillus. Early diagnosis implies the recognition of closed foci in the lungs, which furnish no bacilli-bearing sputum. In a material of 1500 cases at Görbersdorf, in which tuberculosis had been diagnosticated by physical examination, at least one third yielded no bacillary findings, for the simple reason that there was no sputum present.

Weicker also agrees with Knopf that the tuberculin reaction is not available in the diagnosis of human tuberculosis. The public view with suspicion the exhibition of a substance which can produce fever and sensations of discomfort; and some individuals even blame the development of the disease itself to the diagnostic injections made early in its course. Besides, many practitioners do not recognize the trustworthiness of this substance in establishing a diagnosis.

Knopf is supported by Weicker in his claim that red-haired individuals are not especially predisposed to tuberculosis. The Görbersdorf physician examined 4000 tuberculous subjects with this point in view, and found red-hair very seldom present. In this connection the observation by Delpeuch is recalled. The latter found that not the head-hair but the beard and axillary growth are prone to be red in the tuberculous.

Weicker is in accord with Knopf in the belief that heredity does not necessarily mean a hopeless prognosis. Statistics, he states, would show that plenty of cases of "hereditary" phthisis may recover. Attention is called to the observations of Reibmayer, who believes that tuberculous ascendants in time confer a certain immunity upon their progeny. Knopf's endorsement of McLean's explanation of that phase of the phthisical cough which follows change of posture, as well as of Murat's subjective vocal sign, is evidently shared by Weicker.

Knopf's belief in the utility of examining the secretions of the upper air passages for bacilli, is not fully shared by Weicker, for the reason that if they are found in the mucous of the healthy they need not stand in any relationship with the disease.

Weicker is sceptic as to the alleged benefits caused by hemoptysis on the ground that bacilli are thereby cast out of

the body "by the wholesale." The only value of a hemorrhage from the lungs is in the warning it gives.

Knopf advocates the extensive diagnostic use of the thermometer, but does not mention the search for slight elevations after meals and before the menses. Weicker advocates four measurements daily, otherwise the character of the tuberculous fever-wave can not be properly depicted.

Weicker does not, like Knopf, recognize tachycardia as an initial symptom. He fully supports Turban's claim that the rapid action of the heart is due to a tuberculin intoxication.

Knopf is silent as to the precocious urinary symptoms which others assert are found in tuberculosis. These phenomena comprise Teissier's premonitory albuminuria and Michaelis' diazo-reaction. Koppert tested the urine of 100 tuberculous subjects in Weicker's sanitarium and got the diazo-reaction in but a single case.

Under the head of physical diagnosis, Weicker notes the omission of any mention of Krönig's method of apex-percussion.

Knopf's warning against the use of iodides to produce rales for auscultatory purposes is brought by Weicker in association with Kobert's view that these salts mobilize latent foci of strepto-cocci.

Both authors regret that thus far the Röntgen rays have added nothing in certainty to older methods of physical exploration; and both appear to be optimistic as to the probable services which the Gruber-Widal agglutination test may be expected to yield in time.—*Journal of Tuberculosis*, January, 1901.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

The Treatment of the Paroxysmal Stage of Whooping Cough.—*The British Medical Journal* of November 9, 1900, has in it an article by Godson, in which he reminds us that the following drugs have been mentioned as of service in the treat-

ment of this disease: Alum, antipyrin, acetanilid, belladonna, bromide, cannabis indica, carbolic acid, chloral hydrate, creosote, lobelia, opium and its derivatives, phenacetin, quinin, etc.

This list, on account of its prodigality, is confusing to the novice, and appears to show that there is a considerable difference of opinion with regard to correct treatment of pertussis.

Inhalants appear to be in general use, the ones referred to being carbolic acid, creosote, bromoform and chloroform.

The method of treatment Dr. Godson has found most satisfactory is the following: Commence at once with the continuous inhalation of creosote.

Clear the lungs of bronchitis as much as possible before using any special internal antispasmodic remedies. In bronchopneumonia, however, belladonna appears at once to do good. In all cases, if the chest is fairly clear, and the circulation good, antipyrin may be given in suitable doses. Expectorants should be combined with the antipyrin. Good air, warm clothing, light and wholesome food are necessary in all cases. He has followed these rules for the last six years, and is quite satisfied with the results. The average length of time required for cure in a variety of cases last year was 19.8 days, but these figures in no way represent the benefit derived from the creosote treatment. In every case the diminution in the number of paroxysms was so immediate that the patient willingly put up with the inconvenience of the smell of the drug for the sake of its manifest advantage. This in itself is a sufficient testimonial to the remedy to warrant its more extensive employment.—*The Therapeutic Gazette.*

The Use of The Suprarenal Capsule in Diseases of The Lower Air-Passages; A Preliminary Report.—In the *Medical Record* of November 17, 1900, Floersheim reaches the following conclusions:

1. Indications for suprarenal powder: The suprarenal powder is indicated in acute and chronic bronchitis, bronchiectasis, asthma, congestion and edema of the lungs, hemoptysis, and in some cases of pulmonary tuberculosis, especially in those associated with hemoptysis.

2. Method of administration: The suprarenal powder was administered in the form of three-grain capsules on account of their convenience. The powder is to be chewed without water and then to be swallowed in a few moments.

3. Rapidity of the action of suprarenal powder: The action becomes apparent in from two to fifteen minutes.

4. Permanence of the action of suprarenal powder: In some cases the action of the suprarenal powder was permanent, while in the majority of cases the action was temporary, continuing from ten minutes to six hours.—*The Therapeutic Gazette.*

Copper Poisoning.—Dr. H. A. Kurth, *Medical Record*, says: Until the last twenty or thirty years, copper poisoning was not at all common. But with the enormous growth of manufactures in the United States these cases have become so numerous that any physician in a manufacturing city is likely to meet them. The symptoms are as follows: "The face, in advanced cases, has a drawn, anxious expression as in marked phthisis. Anemia is found in all cases. The effect of this upon the complexion is different from that of other anemias. To me it appears several shades darker. The term sallow comes close to describing it. I know of no class of men who can be so intensely nervous as copper workers. Their restlessness is without limit. In their homes they are irritable and excitable. Sleeplessness is, of course, common. Itching and neuralgic pains in different parts of the body are here and there complained of. Emaciation is typical of the disease. One author calls them a 'spare, unhealthy set of men.' The emaciation is not confined to the muscular tissue. Loss of strength naturally follows such emaciation.

The symptoms that are of the greatest value in the recognition of cases of copper poisoning are: (1) dyspepsia, which is the earliest of all symptoms; (2) anemia which also is early and comes before emaciation, loss of strength, or painful facial expression; (3) nervousness and irritability. Add to these the fact that the patient works in copper or brass, and you can not be mistaken."

Department of the Ear, Nose and Throat.

In Charge of Dr. A. W. de Roaldes and Dr. Gordon King, New Orleans.

Atresia of the Larynx Due to Traumatism, the Result of Faulty Intubation.—In the October (1900) number of the *Archives of Pediatries*, W. P. Northrup, of New York, records the history of a case of laryngeal stenosis, presumably of diphtheritic origin, which required intubation.

The intubation was performed by a pupil of the late Dr. O'Dwyer, and under the guidance of that able operator. The operation had to be repeated subsequently two or three times on account of dislodgement of the tube. Tracheotomy was finally required, and later the child succumbed to pneumonia.

Post mortem examination of the larynx revealed an annular stricture at the level of the cricoid cartilage. The author attributes this to laceration of the larynx during intubation, and calls attention to O'Dwyer's repeated appeals for careful and skillful technic and the use of proper tubes.

The Benefit to be Derived from Removal of Enlarged Tonsils and Adenoid Vegetations in Childhood. — In Jacobi's Festschrift, 1900, Huber has summed up in an excellent manner the many good effects to be derived and the ills avoided by proper attention to those lymphoid enlargements in children.

Briefly, his conclusions are as follows:

1. Removal of the lymphoid hypertrophies of the nasopharynx and orapharynx, with care of the attendant nasopharyngeal catarrh will not only restore the permeability of the nose, but if done early will prevent many local pathologic changes.
2. The mental faculties will be improved.
3. The general health will be more or less improved.
4. Defects of speech and hearing due to nasal trouble will disappear.
5. Deafmutism may be relieved.
6. The functions of taste and smell will be restored.

7. Reflex neuroses of various kinds will be favorably modified or cured.

8. Nasal and supposed pulmonary hemorrhages will disappear.

9. Thoracic deformities will be relieved or cured.

10. The tendency to acute catarrhal affections of the respiratory tract and pneumonia will be diminished.

11. The dangers attending the presence of enlarged cervical glands avoided.

12. Lessen the chances of invasion of infectious diseases.

13. The danger of meningeal infection from the naso-pharynx will be diminished.

14. Ear complications in general avoided or rendered less dangerous.

For Laryngeal Tuberculosis.—The following formula is highly recommended by Prof. A. Fasano, of Naples, for local treatment:

℞ Thiocol ..... grs. iss-iiss
Cocaine Hydroch ..... grs. vi
Boric Acid ..... grs. xv
Met. Sig. To be insufflated into the larynx daily.

This treatment is also aided by the internal administration of thiocol in small doses.—*Merck's Archives*, Jan., 1901.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

Section on Ophthalmology of the College of Physicians of Philadelphia. Meeting January 15, 1901.—Dr. P. N. K. Schwenk exhibited (by invitation) a man, 33 years old, with Exophthalmos, the Result of Osteo-porosis. Fracture of the right lower jaw in 1883 was soon followed by gradual enlargement of all the bones of the face, more pronounced on the right side. The bony hypertrophy continued until the right eyeball projected beyond plane of orbit, and was only retained by the orbital tissues. The eyeball could be dislocated at will by patient. Erosion of the cornea occurred from

inability to close eyelids, necessitating a median tarsorrhaphy, while the stretching and lateral pressure caused optic atrophy. According to Agnew, "the osteo-porosis or rarefaction is an osseous change, the result of inflammation, in which the inorganic elements of the bone are measurably destroyed, the vascular canals becoming larger and larger by the absorption of their partition walls until the entire bone, enlarged in the bulk but diminished in its weight, resembles a sponge."

Discussion.—Dr. W. L. Zuill (upon invitation) presented skulls of some of the lower animals affected with the same disease. It differed from osteo-malachia, which affected the long bones, by being restricted to the maxillary bones, and these are generally symmetrically enlarged. The disease is a rarefying and condensing ostitis, the trabecular spaces becoming hypertrophied and filled with embryonal tissue and deposits of osseous neoplasms, which later exhibit a process of condensing inflammation. Although the disease had not been fully studied, he believed the process to be caused by perverted metabolism, probably affected by dietic and climatic conditions, but usually the result of an injury, as in the case exhibited.

Drs. S. D. Risley and E. A. Shumway reported a case of Carcinomatous Degeneration of a Papilloma of the Bulbar Conjunctiva. The tumor involved the temporal half of the cornea, and was accompanied by infiltration of the eyelids at the external canthus. In this position the papillomatous type of the tumor had changed, the cells being grouped in the distinct alveoli characteristic of carcinoma. The eyeball was removed, together with the infiltrated portions of the eyelids, and there had been no recurrence 18 months later. This was the second case of carcinomatous degeneration of a conjunctival papilloma to be studied microscopically.

Dr. S. D. Risley gave the clinical history of a Case of Inflammatory Glaucoma Presenting Unusual Features in a woman, aged 71 years, of gouty diathesis. The attack followed a group of cases of acute conjunctivitis in the family, and was mistaken and treated by physician for that disease for ten days, at end of which time T. $= +3$, vision reduced to fingers at 1 foot, and field narrowed almost to fixation point. She was detained in the office and repeated instillations of eserin solution made, under which the pain subsided and vision

rose to counting fingers at one meter. Before being dismissed she complained of pain in the right eye and dim sight. On examination the anterior perforating vessels were found dilated, anterior chamber shallow, T. = + 2, and pulsiation in the retinal arteries which had before been absent, V. = $\frac{1}{10}$. Under eserin and salicylates, T. normal in both eyes next morning, and in O. D. V. = $\frac{6}{6}$, with normal field, and in O. S. = $\frac{6}{x}$, with temporal field contracted to fixation point and elsewhere to 10 deg. Following attack of indigestion, symptoms returned in O. S. and iridectomy was performed. Two weeks later she suffered an onset of glaucoma in O. D., notwithstanding that eserin had been instilled regularly during residence in hospital. Iridectomy resulted in great improvement in sight in 24 hours, but dimness supervened in 48 hours from extensive hemorrhage which spread over anterior and posterior surfaces of lens. Dr. Risley said that but for the accident of having witnessed the attack of acute transit glaucoma in the right eye prior to the operation upon the left this case would have furnished an illustration of the tradition that iridectomy upon a glaucomatous eye was likely to precipitate an attack of the disease in the previously healthy fellow-eye.

Discussion.—Dr. de Schweinitz referred to an analogous instance occurring in a woman, aged 65, on whom he had performed iridectomy on the right eye for inflammatory glaucoma. From his experience he believed that where acute inflammatory glaucoma attacked one eye, the other eye was almost certain, sooner or later, to be similarly affected, and he strongly advised that an iridectomy be performed on the good eye before an outbreak of the disease had complicated the operation and damaged the eye, especially if at any time, either before or after the iridectomy on the opposite eye, the apparently sound eye had exhibited any of the prodromal signs of glaucoma. In reply to a question by Dr. Harlan, he said that he knew there were cases in which the disease had not shown itself in the good eye even many years after the primary attack in the other eye, but nevertheless he considered that an iridectomy not only relieved the patient of the constant anxiety, but gave the most certain hope of checking the disease. He had been informed by Dr. Borsch, formerly on de Wecker's staff, that that surgeon performed an anterior sclerotomy upon the healthy eye at the time the iridec-

tomy was made upon the glaucomatous ball. In cases of iridectomy in glaucoma de Wecker preferred at first making a sclerotomy, and several weeks later the iridectomy. Dr. Risley said that he was quite in accord with Dr. Schweinitz regarding the advisability of iridectomy on the fellow-eye as a prophylactic measure, since in a vast majority of cases the second eye was also sooner or later attacked by the disease. Iridectomy, he thought, would remove a source of anxiety from both patient and surgeon. During an acute glaucoma the shallow anterior chamber made successful peripheral iridectomy a very difficult operation, and the profuse bleeding from the cut iris often made it necessary to close the eye with the anterior chamber filled with blood, which he believed often led to partial capsular opacity and prolonged convalescence; whereas, in a healthy eye, the operation was comparatively an easy one and fraught with much less danger from complications.

Dr. Zentmayer referred to a case of subacute glaucoma in a patient, 68 years of age, where, 24 hours after an iridectomy, the sight of the fellow-eye, the optic nerve of which presented a doubtful pathologic excavation, rapidly failed, declining from $\frac{5}{6}$ to L. P., with T.+2.

Drs. M. W. Zimmerman and B. K. Chance gave the history and pathologic report of a case of Glioma of the Retina in a healthy girl, 4 years old, in whom there had been no return during the past 5 years. The tumor occupied more than one-half of the vitreous chamber, but the sclera was not involved and the infiltration had penetrated the optic nerve to only slight degree. Histologically it presented the characteristics of glioma.

Louisiana State Medical Society Notes.

The next meeting will take place in New Orleans, April 18, 19 and 20, 1901, and the sessions will be held, as usual, at the Medical Department of Tulane, on Canal street.

THE COMMITTEE OF ARRANGEMENTS ANNOUNCES THE FOLLOWING PRELIMINARY PROGRAM.

LIST OF OFFICERS FOR 1901.

President: Dr. F. W. Parham, New Orleans.

Vice Presidents: First Congressional District, Dr. C. J. Landfried, New Orleans; Second Congressional District, Dr. John Callan, New Orleans; Third Congressional District, Dr. C. M. Smith, Franklin; Fourth Congressional District, Dr. T. G. Ford, Shreveport; Fifth Congressional District, Dr. O. M. Patterson, Bastrop; Sixth Congressional District, Dr. R. C. Webb, Rayne.

Recording Secretary: Dr. H. B. Gessner, New Orleans.

Corresponding Secretary: Dr. A. G. Friedrichs, New Orleans.

Treasurer and Librarian: Dr. H. S. Cocram, New Orleans.

ORDER OF DISCUSSIONS.

[Sections not yet announced will be duly entered for final program as they are reported to the Committee of Arrangements.]

SECTIONS.

Surgery.—Dr. E. D. Martin, Chairman, New Orleans. Subject for discussion, Treatment of Fractures of the Long Bones of the Upper and Lower Extremities.

Genito-Urinary Surgery.—Dr. Chas. Chassaignac, Chairman, New Orleans. Subject for discussson, Treatment of Cystitis.

Materia Medica and Therapeutics.—Dr. L. Sexton, Chairman, New Orleans. Subject for discussion, Is the Tendency Toward Prescribing Proprietary Medicines Increasing; Its Final Effect upon the Professions of Medicine and Pharmacy.

Ear, Nose and Throat.—Dr. O. Joachim, Chairman, New Orleans. Subject for discussion, The Middle Ear Inflammations of Childhood and their Consequences.

The chairman of this section suggests that the subject of general discussion—Inflammations of the Middle Ear in Children and its Consequences—should be divided among the participants of this section for the purpose of *adequate* presentation of this important subject in its entirety to the State Medical Society. Those desiring to assist in this symposium will kindly communicate with Dr. Joachim, 124 Baronne street, New Orleans.

Opthalmology.—Dr. E. A. Robin, Chairman, New Orleans. Subject for discussion, When Not to Operate in Anomalies of the Extrinsic Muscles of the Eye.

Dental and Oral Surgery.—Dr. A. G. Friedrichs, Chairman, New Orleans. Subject for discussion, The Care of Children's Teeth.

Nervous Diseases.—Dr. P. E. Archinard, Chairman, New Orleans. Subject for discussion, Alcohol in Its Relation to Nervous Diseases.

Quarantine and Sanitation.—Dr. E. Souchon, New Orleans, Chairman. Subject for discussion, The Prevention of the Spread of Contagious Diseases; The Period of Incubation of Yellow Fever.

Dermatology.—Dr. J. N. Roussel, Chairman, New Orleans. Subject for discussion, Dandruff.

Practice of Medicine.—Dr. W. Glendower Owen, White Castle, Chairman. Subject for discussion, Scarlet Fever.

Medical Jurisprudence.—Dr. C. D. Simmons, Dutchtown, Chairman. Subject for discussion, Board of Lunacy, with Especial Reference to the Examination of Patients for Commitment in the Insane Asylum.

Obstetrics and Gynecology,—Dr. E. S. Lewis, New Orleans, Chairman. Subject for discussion, Lacerations of the Cervix and their Consequences.

Miscellaneous Subjects.

[In the final program it is the object of the committee of arrangements to have these topics called for at any session where the general discussion on any section has been completed, thereby adding to the interest of each session of the Society.]

1. Over-action of the Heart from Administration of Hyoscin, by Dr. Parsons, of Minden, La.

2. Thirty Cases of Acute Labor-Pneumonia, with Twenty-nine Recoveries, by Dr. Edward D. Newell, St. Joseph, La.

3. Otitis Media Neonatorum, by Dr. O. Joachim, New Orleans.

4. Affections of the Nose and Throat as Factors in Diseases of the Bronchi and Lungs, by Dr. W. Scheppegrell, New Orleans.

The above program is presented with a view to stimulating interest in the discussions at the forthcoming meeting. It is desired that a large attendance be present and that many more papers be submitted for the final program. All communications should be directed to Dr. Isadore Dyer, chairman committee of arrangements, P. O. Box 778, New Orleans.

Notes.

The Recording Secretary, Dr. H. B. Gessner, is authorized to sell to non-members copies of the 1900 Transactions of the Society at $1 apiece. Those members, if any, who have not received the 1900 Transactions will confer a favor by communicating with the Recording Secretary.

Officers of the Society will find the time left between this and the date of the meeting (April 18, 19, 20), none too long for the preparation of the reports expected of them.

Vice presidents in particular should take note of this.

Members of the Society are earnestly requested to furnish the Journal with items of interest about themselves, other members of the Society, or the Society itself, for publication in this department.

Medical News Items.

The State of New York requires four years of nine months study before granting a license to practice medicine. Only registered medical schools are recognized, and a *registered* medical school is defined by law as any medical school, college or department of any university of the State of New York as maintaining a proper medical standard and as legally incorporated. An *accredited* medical school is one that maintains reputable

standards, but does not meet the requirements for full registration. Graduates in liberal arts and sciences, in dentistry, veterinary medicine and pharmacy, and from other professional and technical schools can not be admitted to advanced standing in New York medical schools, and the New York law forbids the registration of any medical school out of the state whose minimum graduation standard is lower than that fixed by statute for New York medical schools.

The Marine Hospital Service has issued a letter of inquiry regarding influenza or grip, with a view to gathering and promulgating some correct information regarding its prevalence and types.

Yellow Fever Immunes are wanted at Tampico, Mexico. Any one interested in having a position as hospital assistant at $125 Mexican, per month, and living expenses, might communicate with Dr. H. S. Squires, Apartado 39, Aguascalientes, Mexico.

Tulane University Notes.—The inauguration of President Alderman is announced for Tuesday, March 12.

A printing department has been established at Tulane with a view of proving self-support to deserving students. It is intended to print all matter incident to the needs of those connected with the university and the equipment is to be sufficient for all purposes.

The Alumni Association project issuing a Tulane album containing views and pictures in half-tone, giving a comprehensive idea of the university.

The American Dermatological Association will hold its next meeting in Chicago, May 30 and 31, and June 1.

The Western Ophthalmologic and Oto-Laryngologic Association will meet in its next annual session in Cincinnati, Ohio, April 11 and 12. A fine program has been arranged and the medical profession are cordially invited to attend the sessions.

American Medicine, Dr. Gould's new journal, is well under way and promises soon to appear. The scheme of financial organization seems to have met with every encouragement.

The Stylus has been consolidated with the *Inter-state Medical Journal*, and the editorial staff in future will include the former editor of the *Stylus*, Dr. William Porter.

A Text-Book of Special Surgery, by Dr. Franz Kœnig, is announced to appear soon from the press of Herbert S. Stone & Co., of Chicago.

Dr. Joseph McFarland, of Philadelphia, has identified himself with Messrs. Parke Davis & Co. in their laboratory for biology. Both Dr. McFarland and this progressive firm are to be congratulated on the association.

The Calcasieu Medical Association met February 1 and elected the following officers: President, Dr. E. J. Lyons, Lake Charles; Vice President, Dr. V. A. Miller, Lake Arthur; Secretary and Treasurer, Dr. O. P. Munday, West Lake.

Dr. D. R. Sartor, who has been located at Alto, La., for several years, has moved to Monroe.

Several of Florida's Quarantine Stations are situated on government reservations, and the State Board of Health has received notice they are wanted for government uses. It is stated that the government intends carrying out the authority created by the act of the last Congress to take entire charge of the quarantine work and relieve the State of the same.

Dr. A. R. Bayley and Dr. T. Engelbach have returned to this city after a long absence.

The Gulf Coast Medical Society, at the meeting on February 16, elected the following officers for the ensuing term: Dr. B. F. Duke, of Pascagoula, president; Dr. J. J. Washington, of Pass Christian, vice president; Dr. J. N. Rape, of Moss Point, secretary and treasurer. The next meeting will be held at Pass Christian on May 1.

Dr. Thaddeus S. Troy, some time with P. D. & Co., is now associated with the Wm. S. Merrell Co., in their New Orleans branch.

At the meeting of the Ascension Parish Board of Health, held February 5, Dr. P. T. Thibodaux read his statistical report to the State Board of Health for the months of October, November and December, showing a total of fifty-two deaths and fifty-three births in this parish for that period. Twenty-nine of the births were white, eleven females and eighteen males, and twenty-four were colored, equally divided as to sex. Several physicians practicing in Donaldsonville and other portions of the parish have made no returns of the births and deaths occurring in their practice.

Dr. J. R. Fridge, of New River, La., has moved to Baton Rouge, and Dr. J. B. Easterly has taken his practice.

Died.—Dr. Cyrus W. Knight.—At Covington, La., Thursday, January 24. The doctor graduated in 1864.

At the last meeting of the Board of Administrators of the Charity Hospital the sum of $50,000 was given by a public spirited benefactor, who desired his name to remain unknown for the present. This munificent gift is for the construction of a suitable building to be used as a Home for the trained nurses.

Dr. C. W. Hilton, of Monroe, is here taking his annual course at the Polyclinic.

The New York Skin and Cancer Hospital announces a series of lectures on syphilis on Wednesday afternoon, beginning March 6 and ending on May 1. The lectures are to be given by the visiting and consulting staffs.

The Annual Meeting of the Association of Medical Officers of the Army and Navy of the Confederacy will be held in Memphis, Tenn., in connection with the re-union of the United Confederate Veteranns, May 28–30 prox.

The committee of arrangements have sent out the following circular letter:

Memphis, Tenn., March 1st, 1901.

Dear Doctor—The Association of Medical Officers of the Army and Navy of the Confederacy will convene in Memphis, Tenn., May 28–30, 1901, during the meeting of the Confederate Re-union. All Surgeons, Assistant Surgeons, Acting Assistant

Surgeons, or Contract Physicians and Hospital Stewards, in the Army and Navy of the Confederate States, and all regular physicians who served honorably in any capacity in the Confederate States Army and Navy, and all regular physicians who are sons of Confederate Veterans, are eligible to membership.

You are cordially invited to attend said meeting and contribute reports of important cases coming under your observation, and any reminiscences worthy of preservation connected with your service in the Army or Navy of the Confederacy.

If you desire to become a member of the Association, and expect to attend the meeting next May, please fill out the enclosed blank and return the same to the Secretary at once, in order that your name may appear on the roll.

Respectfully,

G. B. MALONE, M. D.,
Chairman,
281 Main St., Memphis, Tenn.

A. L. ELCAN, M. D.,
Secretary,
Southern Express Building,
Memphis, Tenn.

The enclosed blank alluded to contains space for name in full, time and place of enlistment; rank at time of enlistment; rank at close of war; character of service—Army or Navy; when and where surrendered; present address, and remarks.

Any further information desired will be most cheerfully furnished by Drs. Malone or Elcan, of Memphis, or Dr. Deering J. Roberts, Secretary of the Association, of Nashville, Tenn.

A visit to Memphis elicits the fact that nothing will be left undone to provide for the comfort, enjoyment and pleasure of the survivors of the late war between the States. Every man, woman and child in Memphis is fully enthused and thoroughly aroused, with a full determination that the occasion shall be both eventful and momentous to everyone who may be so fortunate as to attend.

The doctors of Memphis will see that their end of the line is fully kept up; and with a uniform railroad rate of one cent per mile over all southern and southeastern roads, the attendance should surely be a feature of the occasion.

DR. RANDELL HUNT, of the Shreveport Charity Hospital, was recently in the city for a few days of relaxation.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Practical Gynecology. A Comprehensive Text-book for Students and Physicians. By E. E. MONTGOMERY, M. D., Prof. of Gynecology Jefferson Medical College, etc., Philadelphia. With 527 illustrations. P. Blakiston Son & Co., Philadelphia, 1900.

This recent masterpiece of Gynecology presents a rather new departure from the conventional arrangement of works of this character. The book is not divided into chapters, but rather into sections, each subject being considered with reference to its influence upon the entire genital tract.

While such an arrangement may appear an improvement to the author, the reviewer apprehends it will be more confusing than the old time-honored system.

While the illustrations are magnificent from an artistic point of view, their distribution appears to be unfortunate. There is so much wisdom in the author's statement of the correct attitude of the gynecologist to the patient a full quotation of his opinion must be made. "It should not be considered the true province of gynecology, on the one hand, to ascertain that the patient has a uterus and then to proceed with routine use of speculum, sound and applicator, nor, on the other, after having demonstrated the existence of the ovaries and tubes, to conclude that every symptom of distress or discomfort of which the patient complains must be due to a pathologic lesion in the organs which, of necessity, justifies their sacrifice."

In discussing the treatment of inflammation of the tubes the author says "the rule should be to remove only diseased tissues, but it should be the routine practice, where a gross lesion is limited to one side, that the tube of the opposite side should be carefully examined. If pus exudes from it, notwithstanding the absence of thickening of its walls or of obvious sign of disease, it should be removed." Page 372. Such doctrine is certainly contrary to the teachings of the up-to-date conservative gynecologists, who would simply remove the fimbriated end of the tube, irrigate the canal and stitch the mucous membrane to the serous membrane. But whether their system of treatment is wiser than that advised in this work is questionable.

The treatment of the subject of pelvic tumors is clear and complete.

While the work is sufficiently surgical, there is a pronounced vein of conservatism coursing through its structure that makes it one of the most useful books extant.

MICHINARD.

A Tert Book of the Diseases of Women. By HENRY J. GARRIGUES, A. M., M. D., etc., with 367 illustrations. Third edition thoroughly revised. W. B. Saunders & Co., Philadelphia, 1900.

A third edition following a second in the brief space of two years indicates a great popularity of a medical book; and that this popularity is well merited in the case of this work will be readily by any one who has had the good fortune of its perusal.

While there are evidences of certain alterations and improvements, yet the book remains the same.

We have already published reviews of the first and second editions, that of the former having been rather full.

The author must feel well satisfied with his experience with the medical and electric treatment of uterine fibroids, for he still recommends it to be tried before having recourse to surgical measures. To adhere to such a position requires some courage in this era of surgical aggressiveness. We apprehend, however, that such teaching will have few adherents.

It is encouraging to notice that so great an authority recommends the application of iodin, etc., in the treatment of some cases of salpingitis, a system of treatment that some morbidly operative gynecologists ridicule with the term "tinkering." The Chapter on the Anatomy of the Female Pelvic Organs is probably the clearest and most complete that has ever appeared in any work on gynecology.

The pathology taught of the diseases of these structures is that which most recent investigations appear to show to be correct. The surgical principles advocated are logically conservative, making the work an unusually safe one to recommend.

Taken as a whole, it is probably the best written, the most instructive, the most reliable and the safest text book on diseases of women in the English language. MICHINARD.

Atlas and Epitome of Gynecology, by DR. OSKAR SCHAEFFER. Authorized translation from the Second Revised Enlarged German Edition. Edited by R. C. NORRIS, A. M., M. D., with 207 colored illustrations on 90 plates, and 62 illustrations in the text. W. B. Saunders & Co., Philadelphia, 1900.

In 1897 the reviewer published in this journal a flattering opinion of this work. It was much less complete then than it is to-day.

To briefly explain the character of the work, it might be s'yled a most beautiful, practical and instructive series of pictorial lectures on gynecology. The plates illustrating the pathologic conditions existing in the diseased female pelvic cavity are so true in arrangement and color that one might imagine himself present at an operation. It is only the experienced gynecologist who can fully appreciate the great and valuable aid such a book must be to the student.

The publishers certainly deserve great credit for the artistic finish given the illustrations. MICHINARD.

Obstetrics. A manual for Students and Practitioners. By D. J. Evans, M. D., Montreal, Canada. Series edited by B. B. Gallaudet, M. D., New York. Lea Brothers & Co., Philadelphia and New York, 1900.

This interesting little book will no doubt prove very successful in doing the duty expected of it by the author: "A work that the Student and Junior Practitioner may find of use in attendance on lectures, etc."

Michinard.

Therapeutics; its Principles and Practice. By Horatio C. Wood, M. D., L. L. D., Eleventh Edition. Remodelled and in Greater Part Rewritten. J. B. Lippincott Company, Philadelphia, 1900.

The first edition of this work, issued twenty-five years ago, aided materially in ushering in the scientific study of therapeutics. We know of no other writer in America who has exerted greater influence in bringing the medical profession to a proper appreciation of this most important branch than has Horatio C. Wood.

His giant intellect has given us a work that his confrères in America can well be proud of. The work is a masterpiece of therapeutic literature, showing full well the brain and hand-work of the conscientious and accurate worker. It is in a work of this kind that careful laboratory training and wide hospital experience count. The author shows that he has had the advantage of both. We are glad to add our humble testimonial to this excellent modern work on therapeutics. Storck.

A Manual of Materia Medica and Pharmacology. By David M. R. Culbreth, Ph. G., M. D. Second Edition, Enlarged and Thoroughly Revised, with Four Hundred and Sixty-four Illustrations. Lea Brothers & Co., Philadelphia and New York, 1900.

This edition of Dr. Culbreth's work shows marked improvements over the first (1896) edition. Typographic errors, common to many first editions, have been eliminated. The subject matter has been revised and enlarged so as to make it abreast of modern thought. The arrangement of vegetable drugs has been shaped after Engler and Prantl, so modified, however, as to bring it into nearer conformity to that of Britton and Brown. We consider Culbreth's classification the most scientific, though it is unfortunately at variance, in some instances, with that of our 1890 Pharmacopeia. Where this difference occurs, however, the author gives a parenthetic citation, which is self-explanatory. Doses are given in the metric and apothecary systems. The book does not treat exhaustively of the subject of therapeutics, but deals more particularly with medical botany.

The work is chiefly valuable to students of pharmacy, and it is to these that we especially recommend it. Storck.

Twentieth Century Practice of Medicine, Vol. XX. Wm. Wood & Co., 1900.

The Twentieth Century Practice, with this twentieth volume, reaches

its appointed end, an accomplishment which legitimately earned unstinted praise for the editor and the publishers. This closing volume contains the following subjects: Tuberculosis, Yellow Fever, Poisoning with snake venom, Mushroom poisoning, Diseases of the Uvula, Soft palate and Faucial pillars, Neural and Mental Defects in Children, and the general index

The subject of Tuberculosis alone, including tuberculosis of the skin occupies 394 pages, and this all-important question is presented here as thoroughly as in a special treatise. Yellow fever is written up by Wolfred Nelson, of New York, who has lived in the several habitats of yellow fever for years and knows it through personal experience. There can not be any more interesting reading than this article on a subject so closely related to our prosperity and quiet.

The photos and diagrams in both sections on Tuberculosis and Yellow Fever are very instructive.

All the other articles which are also remarkable in this volume, are written by very competent men. The abundance of the bibliography throughout the work will make the latter still useful for historic reference when age lays on it its inevitable stamp. The index is full and analytic, affording convenience for consultation. DUPAQUIER.

Atlas and Abstract of the Diseases of the Larynx. By DR. L. GRUNEWALD, of Munich. Edited by CHARLES P. GRAYSON, M. D. W. B. Saunders & Co., Philadelphia and London, 1900.

This work is a second and more complete edition of Grunewald's earlier publication of this character. The author has adopted the plan of teaching the diagnosis of laryngeal diseases to the beginner by reproducing in the form of colored figures as near as possible the clinical appearance of those diseases. The book contains 107 colored plates of clear cut clinical pictures accompanied by histories of the cases illustrated. This part of the work, however, is prepared by chapters on the anatomy and physiology of the larynx, methods of examination, the pathology and treatment of the diseases. Its value has already been established by the former edition. DEROALDES AND KING.

Manual of Otology. By GORHAM BACON, A. B., M. D. Lea Bros. & Co., 1900, publishers, Philadelphia and New York.

Less than two years ago the first edition of this work was published by the same author, and he has acceded to the general demand and written this edition.

The character and scope of the work has not been altered, but twenty-five pages of new matter have been added, and the text revised to conform to the theory and practice of the present day. The work is designed as a condensed, practical book for students, and as such it fulfills its mission admirably. DEROALDES & KING.

A Text-Book of Histology. By A. A. Böhm, M. D., and M. von Davidoff, M.D., edited with additions by G. Carl Huber, M.D. Authorized Translation from the Second German Edition, by Herbert H. Cushing, M. D. Illustrated. W. B. Saunders & Company, Philadelphia and London, 1900.

In successive turn each of the structural elements of the human body is brought under consideration and is analytically handled in this text. From the simplest to the most highly organized the tissues of the structures are presented in smallest detail, the technic of the preparation, staining, mounting of each being graphically shown. Great care is evidenced in the selection of illustrations, which are quite numerous and which are of distinct service in elucidating the text. As a text-book, the work before us is in every way adequate, and as a reference book for the practitioner or for the laboratory student it will prove valuable.

Dyer.

An American Text-Book of Physiology. Edited by William H. Howell, Ph.D., M. D. Second Edition, revised. Vol. 1. W. B. Saunders & Co., Philadelphia and London, 1900.

While only a comparatively small amount of new matter has been added to the subjects embraced in this volume, the revision has been complete and the collaborators have tried to maintain the standard which the first edition of this text had assured.

To teachers of physiology especially, the presentation of a comprehensive and exhaustive text is always welcome, and when this is done by a staff of authors such as are collected for this work, the promise of completeness should be fulfilled.

This first volume covers the subjects of the circulation, the lymph, blood, secretion, digestion and nutrition, respiration, animal heat and the chemistry of the animal body, each subject being handled by one of the authors, each of whom is expert in the method of expounding the field of physiology.

Succeeding volumes are promised at an early date, and if these are the equal of the first volume in make up and text, as well as in illustration, the publisher should feel satisfied with the reception which should be accorded it.

Dyer.

A Text Book of Pathology, by Alfred Stengel, M. D. Third edition, revised. W. B. Saunders & Co., Philadelphia and London, 1900.

The third edition of this work has been thoroughly revised and contains 372 illustrations. The illustrations are very good and aid materially in simplifying the subject matter. This work will not only prove interesting to the special student of pathology, but to the general practitioner as well, as the author presents the subject of pathology in as practical a form as possible and from the clinical point of view.

Jno. J. Archinard.

A Text Book Upon the Pathogenic Bacteria, by JOSEPH MCFARLAND, M. D. Third edition, W. B. Saunders & Co., Philadelphia and London, 1900.

The third edition of this work, revised and enlarged, forms a valuable book for students and practitioners of medicine. The volume contains a concise account of the technic procedures necessary in the study of bacteriology, and also an up-to-date description of the life history of the important pathogenic bacteria. The chapters on Tuberculosis, Diphtheria, Plague and Typhoid Fever are very interesting. This volume should occupy space in the library of every sanitarian in this country.

JOHN J. ARCHINARD.

Pathology and Morbid Anatomy. By F. HENRY GREEN, M. D., F. R. C. P. Revised and Enlarged by H. MONTAGUE MURRAY, M. D., F. R. C. P. Ninth American Edition, revised from the Ninth English Edition, by WALTON MARTIN, Ph. B., M. D. Lea Brothers & Co., Philadelphia and New York. 1900.

This being the ninth edition of this work is sufficient evidence of its popularity as a text-book for medical students. It is concise and treats of the subject matter very clearly, omitting no details. The chapters on Malaria and on the Blood are accompanied by very beautiful colored plates. In addition to this, the volume contains a very good chapter on the pathology of the nervous system by Fred. W. Mott, M. D., F. R. S.

JOHN J. ARCHINARD.

PUBLICATIONS RECEIVED.

Transactions of the Mississippi Valley Medical Association, 1900.

International Clinics, Vol. IV., Tenth Series—J. B. Lippincott Co., Philadelphia, 1901.

The Johns Hopkins' Hospital Reports, 1900.

A Text Book on Practical Obstetrics, by Egbert H. Grandin, M. D., and G. W. Jarman, M. D.—F. A. Davis Co., Philadelphia, New York, Chicago, 1900.

American Year-Book of Medicine and Surgery, Two Volumes, by George M. Gould, M. D.—W. B. Saunders & Co., Philadelphia and London, 1901.

The Year-Book of the Nose, Throat and Ear, edited by G. P. Head, M. D., and Albert H. Andrews, M. D.—The Year Book Publishers, Chicago, 1901.

Obstetric and Gynecologic Nursing, by Edward P. Davis, M. D. —W. B. Saunders & Co., Philadelphia and London, I901.

Catalogue Fisk Free and Public Library, 1901.

Report of the State Board of Health of Pennsylvania, Two Volumes, 1899.

Proceedings of the Philadelphia County Medical Ssciety. December, 1900.

Reprints.

Appendicitis—Ventral Hernia following Abdominal Section. By B. Brindley Eads, M. D.

Double Ureter. By John Edward Summers, Jr., M. D.

The Treatment of Epitheliomas of the Skin, with Report of Cases—Lupus Healed with Rœntgen Rays. By Wm. Allen Pusey, M. D.

Twentieth Century Medicine, A Liberal Education. By Allison Drake.

New Points in the Anatomy, Histology and Pathology of the Rectum—New Points in the Anatomy and Histology of the Rectum and Colon. By F. Rawson Pennington, M. D.

Notes on Some Affections of the Heart Substance, With Illustrative Cases. By Thomas E. Satterthwaite, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR JANUARY, 1901.

CAUSE.	White.....	Colored...	Total .....
Fever, Intermittent and Malarial Cachexia	5	1	6
" Yellow			
" Typhoid or Enteric	4	2	6
" Puerperal			
Bronchitis	10	4	14
Diphtheria and Croup	6	1	7
Influenza	17	6	23
Measles		1	1
Small Pox	3	11	14
Pneumonia and Broncho-Pneumonia	45	41	86
Cancer	14	3	17
Consumption (Tuberculosis)	52	49	101
Diarrhea (Enteritis)	20	3	23
Dysentery	2	2	4
Hepatic Cirrhosis	6	1	7
Other Diseases of the Liver		3	3
Peritonitis	1	1	2
Debility, Senile	22	13	35
" Infantile	5	6	11
Bright's Disease (Nephritis)	23	17	40
Uremia			
Heart, Diseases of	40	26	66
Apoplexy and Congestion of Brain	14	7	21
Meningitis	8	3	11
Tetanus	2	3	5
Injuries	21	7	28
Suicide	4	1	5
All Other Causes	81	40	121
TOTAL	405	252	657

Still-born Children—White, 15; colored, 13; total, 28.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 23.14; colored, 33.60; total, 26.28.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure 30.16

Mean temperature ..... 56.

Total precipitation, inches 4.24

Prevailing direction of wind, north.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. APRIL, 1901. No. 10.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

RELATION OF A CASE OF CARDIAC EMBOLUS FOLLOWING FORCEPS DELIVERY; DEATH 15 DAYS LATER.*

BY L. G. LEBEUF, M. D., NEW ORLEANS.

January 22, at 7 A. M., I delivered Mrs. S. B., a primipara, aged 20, of an 8-pound female child. Mrs. B. was a small, delicate, nervous woman weighing 105 pounds. I had been regularly engaged for this confinement, so I had examined her heart and kidneys before—urine chemically twice, and microscopically once; everything was perfectly normal. As she had approached the end of gestation she became considerably nervous and sent for me to tell of her apprehension. I remember specially reassuring her with a statement, then true, that I had not yet lost a case of labor in fourteen years of practice. On January 21, at 3 P. M., I was called to her; she had had slight pains since early morning. Examination revealed a normal state of affairs, os soft and patulous, and I could easily make out the posterior fontanelle in a head presentation pointing towards right sacro-iliac synchondrosis. I left her after ordering a rectal enema. At 10 P. M. that night I was called up again, and then found her in strong, regular labor

*Read before the Orleans Parish Medical Society, February 23, 1901.

pains, and with os dilated as large as a half dollar. Labor proceeded normally until full dilatation of womb had taken place. At about 4 A. M. the bag of waters protruding way down in the vagina, I ruptured to attempt to accelerate matters. The fetal head did not seem to come down in lower strait. I waited two hours longer, and still the head did not pass the brim of the pelvis. My patient began feeling very much exhausted, though her pulse was only 86. Her labor pains became much weaker and the contractions were irregular, happening only if gentle kneading was done, or when she was allowed to walk around. I thought I had waited long enough, and then decided to apply my forceps. It was my third application in four days' time. This was done easily, after boiling instrument, in the regular lithotomy position, hips raised over edge of bed with an assistant holding each leg. The introduction of the blades was carefully performed, after having placed her under chloroform anesthesia. After the blades (I used Holt's modification forceps) were locked and due care was taken of their proper adjustment, I allowed her to rouse up from the anesthetic, and then explained to her, as I always do, taking her as it were in consultation about her own case, what I meant to accomplish and urging her to assist me, *i. e.*, telling her that in this way there was no danger in forceps deliveries, and that I meant her to keep up bearing down with the pains, and that all I would do would be to pull while she bore down. She was very docile, and after about thirty minutes of severe but interrupted traction, I succeeded in getting the head down on the perineum. The moment this was done I removed the blades carefully, and in ten to twelve more pains, or about fifteen minutes more, I delivered her of a flabby, limp, nearly apneotic fetus, without any laceration of the mother's perineum. Expecting trouble with the child I had had some buckets of hot and cold water by the bedside, and for the next twenty minutes was entirely engrossed with the task of reviving the child. I had merely directed an assistant to hold her hand over contracted uterus, and directed another to give one teaspoonful of fluid extract of ergot (Squibb's). Child's heart was still pulsating faintly, and after twenty minutes of continuous exertion it began to gasp in a jerky way. My attention was called at this moment to the mother by a peculiar trickling noise in the

bucket under the edge of the bed. She had a hemorrhage. I began gently kneading the womb and using Crédé's method, rapidly delivered her of a normal looking placenta. I then repeated the dose of ergot and continued the kneading. Very soon the uterus was well contracted. I had it held through half an hour longer. I was then able to attend to her general condition. I found her with a small, fast, wiry pulse; it was 140. Heart tumultuous in action. Respiration was 26, and she looked very pale; she soon became very sleepy. I stimulated her with whisky internally, as well as hot external friction of whisky, hot bottles, digitalin gr. $\frac{1}{100}$, nitro-glycerin gr. $\frac{1}{100}$ and strychnin gr. $\frac{1}{30}$. I kept up this stimulation personally until I secured the assistance of a competent nurse, who was directed to continue the treatment. Patient had not lost very much blood, only about 2 pints; still those grave symptoms kept on and I immediately suspected some heart lesion like a thrombus or embolus and so informed the family. My prognosis was very bad all that day. We added additionally some Ducro's elixir and a little warm milk and warm milk punches.

January 22 (at night) temperature $99\frac{2}{5}$, respiration 28, pulse 150. Still fearing a heart clot I listened carefully to heart and found nothing abnormal except the rapid tumultuous action of the organ. Urine was drawn that night.

January 23, temperature 100, respiration 24, pulse 120, condition much better, patient more aroused, though still intensely anxious. Same treatment kept up, 5 grs. of quinin added and douches of vagina twice daily, 5 per cent. carbolic acid.

January 23, same heart treatment kept up; quite a large clot apparently lodged in os uteri could not be loosened by douching, I was able to easily detach with the finger, some little flow of blood coming after that, I instructed the nurse to give 30 drops of ergot if it kept up. She gave two doses. All this time patient was also under quinin 5 gr. 3 times daily. That day, pulse was 115, temperature $99\frac{3}{5}$.

January 24; patient went on improving, though pulse remained at 108–112.

January 25; temperature went up to 102, pulse 126; gave a dose of castor oil.

January 26: Temperature $100\frac{2}{5}$, pulse 115, respiration 20.

January 27: Temperature $99\frac{4}{5}$, pulse 108.

January 28: Temperature 98⅖, pulse 92.

January 29: Temperature 98⅖, pulse 92.

January 30: Constipated since purge of 25th; gave one-half glass of Hunyadi water, no effect; and 1½ ounces of castor oil. She was griped considerably and complained of violent pains in region of uterus. She was very freely purged but was very nervous from this experience.

January 31: Lochia normal, temperature normal, pulse still ranging between 88 and 96.

All through this time she complained of a peculiar feeling of fear or unrest; when you would question her and try to pin her down to an exact statement of the cause of that fear she could not define it, but she was afraid to move in bed even to turn on her side. She described the feeling that when she turned over her entire chest seemed to flop over on that side (that was her expression). Still, after that date she did wonderfully well, nursed her child entirely after the first three days, and up to the time of my last visit, February 5, exactly two weeks after confinement—on that day she was perfectly well, and began raising herself up in bed on pillows. Her temperature was normal, pulse 80, respiration normal. I again listened to her heart, found all sounds normal, and joked with her about her fear of getting on her side, and told her to get up next day for half an hour. I then took my leave of her, feeling absolutely assured about her condition. Met her husband that day and told him I had made my last visit. Next morning at 6 A. M. he rang up my telephone and said: "Doctor, my wife is dead." At 11 P. M., February 5, he was called from his sleep by his wife, she was nursing her baby, and she said to take the child, as she was suffocating. She had him to remove the bed clothes, and began to pant for breath. She was conscious then; soon she lapsed into unconsciousness, clutched with her hands for air. Before losing consciousness she said she felt as if some one was clutching at her very heart. She became cyanosed and in 9 minutes died in a convulsion or tonic spasm. A physician of the neighborhood was called, but he arrived too late.

NOTES ON CARDIAC EMBOLISM.—Few complications in the practice of midwifery attain the gravimen of type which heart coagulum or embolism does. Fortunately a rare affection, still it is one of the most terrible conditions

which the modern accoucheur has to guard against. It comes generally as suddenly as a thunderbolt from a clear cloudless sky. Even if it is suspected, the therapeusis applied to it, is almost nothing, and the mortality is tremendous. Professor Virchow gave us the first pathologic explanation of the phenomena of thrombosis and embolism. He also explained to us how an embolus is caused by the detachment of an enfarct or clot of blood or other solid matter thrown in the vascular circulation and propelled in the direction of the flow of that current until it meets its first resistance. It is easy for us to understand how a recently gravid uterus can cause an embolus, when we remember the great number or plexus of veins coming from the enlarged uterine sinuses which empty directly into the inferior vena cava; it is very easy for a small piece of fibrin or a solid clot to be conveyed to the heart and there meeting an obstruction it is arrested or adheres to the sides and rapidly adding to its proximal end, increases so, that the entire right heart is entirely filled up. Virchow believed that coagulation begins in any of the small minor veins, which opening in the right auricle can easily give rise to thrombosis in that site, and cause death. Dr. Meigs called attention in 1849 to death following a *formation of a fibrinated coagulum.* He believed that after labor a woman who had lost 40 ounces or more of blood was more liable to heart clots, because the balance of her blood supply was more coagulable. His reasoning is thus: In fainting, a temporary syncope is produced, by a diminishing supply or a lessened blood tension in the encephalon. In embolism the dimished blood pressure, after a large loss of blood, diminished the tension in the circulation and allows it to become so weak that the current practically stops, and allows the blood to coagulate or to adhere as fibrin or laminæ of fibrin to the walls of the right heart. Then, to use his own words, "In so much as the venous blood can only get back to the arterial side by passing through the right or pulmonic heart such a clot then, if large, must either wholly or partly stop the flow of the venous blood. It is like a ligation of the inferior vena cava." Meigs, W. S. Playfair and Fordyce Barker believed also in the spontaneous coagulation on account of the larger proportion of fibrin in the blood at the time of labor. Spiegelberg states that the emboli which become detached during or

shortly after labor proceed from clots formed at the site of the placenta. After the detachment of the placenta if a sudden hemorrhage syncope follows weakening the heart's action so much that it causes the formation of large soft clots, extending from the relaxed gaping mouths of the uterine sinuses towards the direction of the heart, these can be set loose at any time and thrown into the heart. The principal predisposing causes to the diseases are the use of forceps, of anesthesia, severe laceration of cervix or perineum and post-partum hemorrhage. The symptomatology is unfortunately too plain. A peculiar sense of unrest, of disquiet beforehand, an undefined fear out of which the patient cannot be reassured, the suddenness of the onset, a rapid tumultuous pulse, sometimes irregular, a distinct bruit, heard frequently over the heart more like an aneurismal rasping bruit than a heart murmur. No fever, though pulse keeps rapid. The attending physician may have used all the means at his command. He may have been looking for this very complication, kept his patient in absolute rest (as in my case), given all the cardiac stimulants possible, and still the patient will be taken suddenly with this terrible *besoin de respirer*, like some one clutching at her heart with a mailed hand. This struggle for breath lasts a few minutes, frothy mucus comes to the mouth from the fearful efforts of the pulmonary circulation; if time is given for diagnosis subcrepitant râles are heard, the pulse is lost, cyanosis supervenes and sometimes the entire body is shaken in frightful spasmodic movements or convulsions. The mind is clear at first, and patients generally speak until the last few minutes before dissolution. The differential diagnosis is principally with some obscure forms of serious peritonitis, where the pulse is also small and rapid and where death is also quite sudden, following very little fever. Heurieux and Playfair taught, half a century ago, that the state of hyperinosis and anemia or asthenia in which all pregnant women found themselves, increase their risk, especially after hemorrhages, towards thrombosis and embolism. The disease is very often a sequel of phlegmasia dolens. Fordyce Barker deduces that death rarely happens from an enfarct in the heart, or pulmonary artery, before about eighteen days after labor, because he believes that it takes all of that time for an embolus to be detached from a

thrombus in a peripheral vein, and for it to be able to soften enough to be detachable; my case happening on the 15th day after labor, would not be embolic, according to this reasoning, still, it could not be due to pulmonary thrombosis, because there was no pulmonary lesion whatsoever, no cough, no marked temperature, no dullness of lung, no lobular pneumonia. Yet death can happen suddenly from pulmonary artery thrombosis also. The pathologic appearance of the heart after death shows the right side of the heart swollen and immensely distended; on opening the cavities, the right auricle is found filled with a hard leathery mass of colorless clotted blood, sometimes laminated. The treatment that recommends itself is first and principally, rest, absolutely supine, horizontal rest, for 3 to 4 weeks; 2nd, alcoholic stimulation, and the various other heart stimulants, nitro-glycerin, digitalis, strychnia and the ammonia preparations. The only thing that I would do also, that I probably should have done in my case, is to at once stop the nursing of the child. In my case everything looked so promising, and I had such nervous a patient to deal with, that I preferred to let her have her child rather than to increase her nervousness by taking it away from her, and thereby arousing her suspicion regarding the gravity of her condition.

A CASE OF SUPRA-VAGINAL AMPUTATION OF THE UTERUS FOR FIBROIDS COMPLICATING PREGNANCY.*

By C. JEFF MILLER, M. D., Chief of Clinic to the Chair of Obstetrics and Gynecology in The New Orleans Polyclinic, New Orleans.

Fibroids of the uterus complicating pregnancy present some features for study which are of equal importance to both physician and surgeon. It has long been known that in the presence of such growths the chance of pregnancy is greatly lessened, and when pregnancy occurs the risk of abortion and untoward complications are correspondingly increased; so it behooves the physician to be thoroughly acquainted with the conditions that may arise in consequence of these changes and advise the proper treatment when indicated. There is no affection capa-

* Read before the Orleans Parish Medical Society, February 23, 1901.

ble of producing more insuperable obstructions to labor than a fibroid situated in the lower segment of the uterus, besides complicating the puerperium, producing mal-positions of the child, predisposing to adhered and misplaced placenta, prolapse of the umbilical cord, and troublesome hemorrhage. Fortunately the tumors which are a bar to delivery (those situated on the lower segment of the uterus and on the broad ligaments) are also a bar to conception, else the surgeon would be brought to face some of the most trying situations in operative obstetrics much more frequently. Tumors occupying the upper portion of the uterus, especially if subperitoneal, rarely demand surgical intervention unless their size prevents the uterus rising to accommodate the growing fetus, or they undergo inflammatory or cystic degeneration, to which they are particularly liable during pregnancy. If situated on the anterior wall of the uterus, labor pains and the contraction of the longitudinal muscular fibres of the cervix may force it above the pelvic brim, even when manipulation under anesthesia has failed before labor supervenes. Cases are also reported where the tumor, together with the anterior lip of the cervix have been forced out of the vulva, thus avoiding an obstruction.

Fibroids situated in the broad ligaments are more liable than all others to successfully obstruct the parturient canal. While the broad ligaments undergo changes corresponding to the uterus during pregnancy the folds are unable to accommodate a growing fibroid, and such growths are usually found quite fixed in their position and can not be pushed in any direction. The same may be said of growths on the posterior uterine wall. Unlike those situated anteriorly they are forced further into the pelvic cavity as labor advances and each pain serves to further fix the mass in its position. Under complete anesthesia it is often possible to push the growth sufficiently above the pelvic brim to allow delivery to be completed but unfortunately too many growths about the cul-de-sac of Douglas assume a shape which exactly fills the sacral curve and promotes the formation of a dumb bell shaped growth which can not be pushed above the pelvic brim. Another point to be remembered is that such growths, especially when present in young women, influence the deepening of the pelvis to such an extent that labor may be seriously complicated even though the tumor has been removed. The first

method of treatment which suggests itself, is the induction of abortion. Experience has shown, however, that such practice is particularly dangerous, owing to hemorrhage and sepsis which too often follow manipulation of such growths, owing to their very low vitality. The physician should ever bear in mind this tendency to gangrene and sloughing which may follow the inevitable bruising necessarily caused by dragging the child through the parturient canal. Even though the canal may admit delivery by forceps or prolonged labor pains, it may sometimes be more conservative to resort to Porro-Cesarian section, especially if the body of the uterus also contains growths, for the number of instances in which rupture of the uterus occurs is sufficient to keep the matter constantly in view. When tumors are found complicating early pregnancy and it becomes necessary to determine whether the pregnancy should be allowed to proceed to term, it should be remembered in making calculations that fibroids often grow very rapidly when stimulated by the increased blood supply incident to pregnancy, and that they are particularly liable to inflammatory changes. Such sudden increase in size, especially when the growth is situated in the lower uterine segment, rapidly increases any pressure symptoms that have previously existed. In fact, this symptom is the one which usually causes the woman to seek medical advice. Interstitial tumors grow more rapidly than the other varieties, the subperitoneum form being the least affected, especially when near the fundus. Pregnancy rarely occurs where subcutaneous growths exist, and practically always ends in abortion at an early stage. Polypoid growths that obstruct labor usually originate in the cervical canal or the anterior cervical lip, and are mucous in character. They may increase very rapidly during pregnancy, but their pedicle is usually small and easily removed at the proper time. According to Hurst, such an operation should be postponed until labor commences, for any manipulation about the cervix is peculiarly liable to interrupt gestation.

The prognosis depends upon the variety and situation of the growth. It may be stated that the higher the situation of the growth and the nearer it approaches the subperitoneal form the less the danger of complication.

Hirst states that in general practice the results have hitherto been bad. Nauss found a maternal mortality of 54 per cent.

among 225 women and an infantile mortality of 57 per cent. in 117 cases. Susserott found about the same.

Brooks H. Wells in a late study states that, excluding subperitoneal tumors of fundus, the maternal mortality in labor complicated by fibroids has been in the past over 40 per cent. and the mortality to the fetus nearly as much.

The diagnosis of tumors obstructing the pelvis in pregnancy and especially during labor is unfortunately difficult in many cases. It has been mistaken for the fetal head or an undilated cervix and the woman permitted to die of ruptured uterus, or exhaustion before the condition is realized. Also in the cases of early pregnancy (six weeks to four months) it is in some cases exceedingly difficult to state positively that pregnancy is present if the tumor is well fixed in the pelvis and has added to its own obstruction that of a pronounced pelvic congestion and possibly some inflammatory changes. It may be necessary to observe the growth for some time and make frequent examinations (even resorting to general anesthesia) before a conclusion may be reached. The subjective signs are of value and should be gathered very carefully. Within the past year I have had the privilege of observing two such cases, one in my own work, the other in the hospital service of Professor E. S. Lewis, and while pregnancy was strongly suspected in both cases all the subjective signs being present, the diagnosis could not be positively made by bimanual examination until chloroform was administered, owing to the fixed position of the tumor and uterus and congested surrounding tissues.

The following brief history was gathered from a patient referred by Prof. E. M. Dupaquier, November 12, 1900:

She was a woman 31 years of age, of small physique and nervous temperament who had always enjoyed good health until two years before consulting her physician, excepting an attack of small-pox during early youth. Her menses appeared when she was 15 years old and continued normal until late in 1898. She then began to notice a slight increase in the flow and duration of the menses which continued until September, 1900, when the period was missed. It failed to appear in October and November, except on one or two occasions a slight stain was noted for a few hours. Soon after the menses failed to appear for the first time she began to experience attacks of backache, which finally became constant and occasionally

almost unbearable. Strange to relate no nausea or vomiting was present at any time, although her appetite was capricious and she sometimes complained of gaseous distension of the stomach. She did not deny the possibility of pregnancy, a point which first called attention to the true condition.

A digital examination revealed the cervix rather low and pushed firmly against the left pelvic wall. The body of the uterus could be defined only a short distance and seemed to lose itself in the hard tumor found filling the right half of the pelvic cavity and sacral curve. Pressure had caused considerable congestion and tenderness which militated against satisfactory examination. Six days later she was again examined and little change in the growth had occurred. The cervix seemed somewhat lower and the pulsation of the uterine vessels more distinct. As she was suffering considerably from the backache and the tumor was found so immovable, operation was advised. Two days later the abdomen was opened and the uterus, together with a large interstitial fibroid filling the right broad ligament was removed. A fibroid about the size of a hen egg was found in the left broad ligament and removed.

Supra-vaginal amputation was done, and the stump covered with peritoneum, and the ovaries were left intact. Considerable oozing occurred from the broad ligament folds which covered the growth, but this was easily controlled by hot saline solution, and the abdomen closed without drainage. Her recovery was uneventful. On the second day the temperature reached 100 deg. once, then declined to normal, and fluctuated below 99½ for some days. The sutures were removed on the tenth day, and she left the Sanitarium on the eighteenth day. She has been seen several times since and is enjoying the best of health.

The growth together with the uterus and a three months' fetus weighed five pounds and three ounces the day it was removed.

The fibroid was internally connected along the whole length of the uterus. The anterior wall of the uterus was unusually thin, showing that the increase in the uterine cavity was at the expense of the wall in one direction.

REFERENCES.—Hirst—Text-Book of Obstetrics; Wells—*Medical News*, 1900; Delaginere—*American Journal of Obstetrics*, June, 1900; McMurtry—*Journal of the American Medical Association*.

Clinical Reports.

ANKYLOSIS OF THE TEMPORO-MAXILLARY ARTICULATIONS; WITH OSTEOCLASIS AND FORMATION OF NEW JOINTS.

By PAUL A. McILHENNY, M. D., Assistant Surgeon, St. Joseph's Hospital, Chicago.

In reporting this case it is merely my desire to give an idea of the patient's previous history, the operation, and treatment he received while under my care in St. Joseph's Hospital.

Mr. Robert D., 24 years old, a native of Mississippi, came to the hospital in June of 1900. When he was nine years old, he was subject to attacks of malaria; during one of these attacks he had hematuria, and was progressing very nicely on a treatment of quinia and salts, when his family, without medical advice, gave him a large dose of calomel. After a lapse of twelve hours the child's mouth became very sore, and opening and closing the mouth caused great pain in the muscles of the jaw. After twenty-four hours, a second large dose of calomel was administered, which after a short time increased the soreness in the mouth and jaws. The physician was called, and on examination found a severe case of ptyalism. He prescribed the proper antidote and also gave a mouth wash, which when applied to the sensitive mucous membrane caused excessive pain.

The parents did not insist on the child using the wash, and in a few days the muscles of the jaw became so stiff and sore that the child could not open his mouth. This contraction and stiffness increased and was so great that wooden wedges were forced between the teeth to pry open the jaws. Nothing, however, was accomplished by this treatment, and two weeks after taking the first dose of calomel the jaws were so immovable that two teeth had to be removed so that nourishment might be given.

Gradually the child overcame the mercurial poisoning and the soreness passed away, but the effects of the excessive ptyalism still remained; the jaws were still closed, and the contracted muscles began to atrophy. In the course of time the patient was taken to a surgeon who endeavored to break the adhesion,

but after trying several times he abandoned the idea, fearing that the jaws would be fractured.

Several other attempts were made but all were unsuccessful, and after a lapse of fifteen years the patient decided to come to Prof. Senn's clinic.

On inspection we found the superior maxilla well developed, but the inferior much smaller than normal, and decidedly deformed. The teeth were all necrosed more or less, and had grown toward the center of the mouth, thereby forming an angle with each other, with the apex pointing inward.

On examining the inner surface of the cheek, a band was found on each side; these bands appeared to be formed by the adherence of the cheek to the upper and lower jaws, while the mouth was inflamed. After carefully examining the temporo-maxillary joints, they were found to be completely ankylosed and immovable. The question than arose whether to try to break up the adhesion, or to perform osteoclasis through the neck of the condyle, and make a new joint; the latter operation was decided upon, the masseters and pterygoids having been found to respond slightly to electricity. Esmarch's incision was made on the right side, the flaps dissected up, and turned back, thereby exposing the jaw bone from the sigmoid notch, to a joint a little anterior to the angle of the jaw. The masseter was then retracted and by careful chiseling a wedge of bone about a half inch in diameter at the base, with the apex pointing in the sigmoid notch, was removed from the neck of the condyle just above the insertion of the external pterygoid. The same steps were followed on the left side, and we were then able to open the jaws to about normal. The tongue was then found to be attached along the lateral edge, from the base to very near the apex, on the right side to the mucous membrane of the jaw, this being greatly impaired in its function.

After rounding off the ends of the bones, strips of iodoform gauze were put in for drainage and the wounds closed. The wounds were irrigated every day with a solution of boric acid, and Thiersch's solution was used as a mouth wash. At the end of the third day passive motion was begun with a mouth gag, opening the jaws as far as possible with moderate force; the faradic current was also applied to the masseters and pterygoids for a half hour each day; this treatment was kept up for a

month, the patient using the gag himself at intervals of an hour during the day. At the end of this time he was able to open his mouth to quite an extent and close it with a good deal of force. In order to develop the muscles and assist their functioning, I had the patient chew about three sticks at a time of the ordinary chewing gum, between meals; this I think helped him considerably, as it prevented the muscles from regaining their stiffness after the electricity had been given. The bands on each side of the mouth had given us some trouble in using the gag besides being very painful; therefore after having accomplished nothing by trying to stretch them, they were cut about two-thirds through and then stretched; this brought prompt relief and wonderful improvement. The necrosed teeth, which were merely snags, were all extracted and Thiersch's solution was again used as a mouth wash.

In a short time the gums had healed and hardened, then the patient consulted a dentist and had plates made. The external wounds were very obstinate and took some time to heal, but finally they closed and the new joints were perfect. The patient was soon able to chew his meals for the first time in fifteen years, and was discharged cured.

THREE CASES OF OCULAR DISEASE.*

By M. FEINGOLD, M. D., New Orleans.

Case No. I.—Colored child, five months old. When the child was one month old the mother said she first noticed that the child's eyes were white instead of black; previous to that she never noticed anything wrong about the child's eyes; no swelling, no discharge. Following her neighbor's advice she bathed the child's eyes with borax and rosewater; the trouble gradually became worse until it reached its present state; the mother suffering from *fluor*. At the first aspect we notice that the eyballs seem to be too large for the lids; the lids never being closed tightly; this symptom being more pronounced on the right eye; conjunctivæ palpebrarum et bulbi normal in both eyes; the cornea forming the peculiar feature of this

* Exhibited before the Orleans Parish Medical Society, March 9, 1901.

case, they appearnig bluish-white, like thin transparent porcelain; the surface of the cornea perfectly smooth, but slightly hazy in left eye; in the right one the periphery of the cornea exactly as in the left one; in the centre of it a small protuberance blacker than the environment of a diameter of 2 *mm.*, at which place a superficial ulcer existed three weeks ago. Through the opaque cornea of the left eye no iris can be made out, but in the centre of it a black circular spot indicates the position of the pupil, on the size of which belladona has no influence; of the deeper structures nothing can be made out; tension increased in both eyes; eyes wander about aimlessly.

The peculiarity of this case of undoubted ophthalmia neonatorum lies in the blindness produced by a parenchymatous keratitis and iridocyclitis without the usual perforation of cornea and prolapse of iris; in other words, the child became blind not in the usual way when the cornea is attacked first, then perforated, and the perforation closed up by the prolapsed iris, but a perforation of the cornea and a prolapse of the iris never occured in this case, only cornea, iris and deeper structures were evenly attacked by the virus, which in this case did not act destructively, but plastic.

CASE NO. II.—Colored boy, age 11. When about 4 years of age mother first noticed "a skin growing over his eyes," it soon reached its present state, and has become stationary since; the boy complains of fearful itching, which makes him rub his eyes continually.

The child shows symptoms of hereditary specific disease, has large head, flat superior maxilla, defective teeth. The upper lids cover more than half of the cornea, and when told to open the eyes, the boy frowns his forehead when raising his lids; in looking upward the lids promptly go up; conjunctiva palpebrarum normal in both eyes; no scars; conjunctiva bulbi slightly injected; slight pigmentations on the outer and inner side of each cornea; the conjunctiva bulbi appears to be drawn over the cornea to the extent of 1 to 2 *mm.*, all around the limbus appearing gelatinous, with slight prominences at the inner and outer sides of the cornea, thus limiting the translucid normal cornea to a very small disk with irregular borders, and giving the eye a peculiar expression as if the bulbus were too large for the cornea; the central part of the cornea, anterior

chamber, iris and media normal, viscus normal. This case represents, in my opinion, a rare instance of the rare spring catarrh, in which the conjunctiva palpebrarum is entirely normal. During an observation of eight (8) weeks no ulcer of any form appeared in the affected parts, the conjunctivæ getting only more injected when the boy had played on the street.

Case III.—White girl, age 18. Two days after being shot in the left eye with an air rifle by a boy across the street, applied for treatment. At that time, about six weeks ago, the eye offered the following status: conjuctival and ciliary injection, ecchymosis on medial side near the cornea, near the horizontal meridian, in the conjuctiva bulbi; at this point a wound with straight edges about 2 *mm.* long, at the bottom of which the underlying sclerotic also seems affected; this wound extends into the cornea about 1½ *mm.* in a straight line affecting the superficial layers; the balance of the cornea is hazy, less transparent than normal. In the interior chamber liquid blood up to ⅓ its height; iris, appearing greenish, at a point where the above named wound crosses the limbus, turn off from its attachment to the extent of 4 *mm.* leaving a black space between itself and the limbus. Fundus could not be seen. Vision: fingers at ½ metre. Under atropin, hot applications, salicylate of sodium and rest, the ecchymoses, hyphemia disappeared, the eye got perfectly pale, and the vision returned to its normal state. No foreign body could be detected in the eye. The reason for presenting a case of the rather common iridodialysis lies in the perfect linear, apparently superficial, wound of cornea and sclera, without an escape of humor and prolapse of ciliary body produced by a dull force.

Case No. IV. Farmer, white, 38 years old. Four weeks prior to his calling at my office, he tried to cut the link of a chain, the chisel rebounded, and flew in his right eye; the eye became blood-shot, painful. He was treated with hot applications and belladonna; his sight returned, only a black spot continually remained to be before his eye; on account of which he consulted me. *Status presens;* vision in right eye ⅚, left eye ⅚, but complains that the letters are not as distinct with the right eye as they are with the left one. The ophthalmoscope revealed as the cause of the black spot a few opacities in the vitreous body.

N. B. The fundus appeared to the direct examination as through a thin veil; near a branch of the arteria temporalis superior, way near the equator and parallel to it, a rupture of choroidea and retina, about 8 papillary diameters in length and about 1½ to 2 diameters wide, at the bottom of which rupture the white sclera, some fresh blood and brown detritus can be seen.

This rupture of the choroidea and retina that gave no subjective symptoms is an illustration of the effect of *contre coup;* for the chisel never could have struck the upper half of the ball, it coming from below, and the eye instinctively always turning upward in case of danger.

Clinical Note.

SUPRARENAL LIQUID WITH CHLORETONE IN RHINOLOGY.

By CHAS F. SAUTER, M. D., New Orleans.

I have recently been testing the therapeutic effects of this preparation in chronic hypertrophic rhinitis, with excellent results. In one instance the patient had suffered for nearly two and one-half years. For eight months or more I had endeavored to give relief with other remedies, but with no success. My attention was then directed to suprarenal liquid with chloretone, and I determined to make a practical trial of it in this case. At the present time I have used about one-half fluid-ounce of the preparation and the patient is to all intents and purposes cured. I say cured, because the nasal chambers are clear and the breathing is unobstructed, while before treatment mouth-breathing had been the rule.

My method of using the remedy was to make topic application of it with a swab of cotton on a probe. The saturated cotton was passed four or five times into each naris, thoroughly coating the inferior turbinate with the solution, the treatment being repeated three times weekly for one month, then twice a week until the present time.

N. O. Medical and Surgical Journal.

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

HOME FOR LOUISIANA CONSUMPTIVES.

In a report to the State Board of Health a committee from that body sums up the question of the control of tuberculosis in a proposition and recommendation for "the erection of a thoroughly equipped sanitarium, supplied with all the tents and paraphernalia necessary for such patients as may require exclusive open air treatment."

In the whole world medical thought is active in the study of a solution of the problem of the "White Plague," and until now remedial measures have in most part been directed at therapeutic methods, all aimed at the destruction of the bacillus and its colonies. Rational thought has of recent years recognized the importance of hygienic measures, and in various parts of the world sanitariums for consumptives have been erected and put in operation. Each of the countries of Europe has been active in this matter, and London for many years has made such provision for its consumptives. In Egypt, special buildings have been erected for the better classes of the tuberculous wintering there, and all through the land of the "*dolce far niente*" attractive resorts have arisen to meet the logical demand.

Not long ago some idea of the prevalence of consumption in New Orleans was brought out, when the several serum treatments were on the market for investigation and experiment, and it was shown that for a period of fifteen years between 20 and 30 per cent. of the total mortality in this city was from tuberculosis. As the sanitary condition of New Orleans has improved, and as it will improve, the prevalence of tuberculosis must grow less. With the anti-spitting laws in force, with a better and higher intelligence for self protection on the part of a newer public, the provisions for that public's protection can be the better fulfilled. In this direction of thought the proposed home for consump-

tives is a timely and wise idea. Dr. Tolson, of Covington, and the committee of the State Board of Health, consisting of Drs. W. G. Owen, White Castle, Arthur Nolte, New Orleans, and T. T. Tarlton, of St. Landry, and *The Times-Democrat* are to be cordially commended for promulgating the spirit which is bound to grow into larger and larger action in New Orleans and Louisiana until the projected idea takes shape in a monument of a logical philanthropy.

The proposed home for consumptives, to be located on the land donated by Dr. Tolson, of Covington, should be in all ways adequately conceived before it is begun. It should command funds enough to have a perfect administration, and this should be guaranteed. We believe that the very need of such an institution will make the public conscious of the necessity of giving to help it; but to have an institution complete and creditable, much money will be needed.

We need only point to a no less evil, leprosy, in the State, and the lack of adequate medical provision and of public protection to urge that if the people are to provide the funds that they should do it largely, for the institutions of the State which are at the present time apart from private charity and philanthropy are hardly cynosures.

THE NEW MEDICAL LAW OF TEXAS.

We are glad to notice that Texas legislators have finally responded to the repeated demand of medical men in the State for proper legislation to regulate the practice of medicine. While in some respects inadequate, the new law covers the need of so large a territory as Texas and promises a future standard we are sure the medical profession of that State will see maintained. The law provides three boards, the Board of Medical Examiners, the Board of Eclectic Medical Examiners and the Board of Homeopathic Medical Examiners; each Board consists of nine members appointed for two years and it is provided that no member shall be a professor or teacher in any medical school.

Among other provisions of the new act we notice that it is required that members of each board shall have practiced five

years or more; that they shall be selected from a list of twice of their number furnished and recommended by their respective medical societies; the Governor to have the right to refuse all recommendations and to require others, and that vacancies shall be filled by the Governor from the lists in his hands; intoxication, the habitual use of morphin and other such drugs disqualifies; one year must elapse before re-examination of those rejected, nor can one Board meanwhile license a person rejected by one of the others; no diploma or certificate of graduation is required and discretion as to qualification rests entirely with the examining board, who may determine from a written application for license whether the candidate is eligible for examination or not.

The act is not retroactive against those who have complied with the law previous to the promulgation of the present act. The law is specific in recognition of the license granted by other States were the standard is adequate. Any person shall be regarded as practicing medicine within the meaning of the act who shall profess publicly to be a physician or surgeon, and shall offer for practice as such or prescribe for those needing medical or surgical aid, and shall charge or receive therefor money or other compensation. No profession of faith in a particular school is required, and the candidate may elect examination from any of the three boards.

An excellent provision is made to include the restriction of "persons not pretending to be physicians who offer publicly, on the streets or other public places, remedies which they recommend for the cure of diseases;" but we can not understand why proprietary medicines and other nostrums dispensed by druggists and others should be permitted by the clause qualifying the above and which reads: "Not manufactured and compounded within this State;" a clause which emasculates that section of the act so far as the protection of the public against drug-store counter-prescribing and newspaper nostrum-advertising is concerned.

The punitive clauses are sufficiently stringent, and it remains to be seen that the profession of Texas are sufficiently interested in their own cause to require the fulfillment of the letter of the law.

It is a long way yet to the education of the public to the needs

of their own self-protection, and we feel sure that the Texas State Medical Association, with this much won, will look in the future to the revision and amendment of the act, so as to prevent the inflow of the *omni*paths of miscellaneous mongrel medical schools into their newly rehabilitated community.

THE MOSQUITO THEORY OF YELLOW FEVER.

The experiments on human subjects in Cuba seem to have settled one fact, viz; that the mosquito does bear the element of icteroides and that the culex fasciatus is most of all to be dreaded in tropic and temperate regions. It is not yet time to look upon the mosquito as the sole source of origin of yellow fever; but enough has been demonstrated to create in the minds of thinking people the urgent necessity for destroying the mosquito and its breed. Nuttall, in his elaborate monograph on the subject of insects and disease, has elaborated a variety of measures for the destruction of the mosquito. Our health authorities are now advised of the need and the method and it requires only an appreciative and co-operating public to see to the destruction of the mosquito in this section of the country. In infested countries, like India, circulars of instruction are promulgated and regulations of the health authorities are made stringent in their enforcement. Where so much is at stake, our community should be ready for the crusade as soon as the way is demonstrated. All honor to Drs. Reed, Carroll and Agramonte, and let us also add the names of Manson and his kind!

THE STATE MEDICAL SOCIETY.

In a few more days the State Society will meet in New Orleans and everything points to a successful gathering. Every effort should be made by the country members to attend, for it is only by such association that we advance in profession and in fraternity. Remember the 18th, 19th and 20th of April!

Society Proceedings.

ORLEANS PARISH MEDICAL SOCIETY.

Meeting of February 23, 1901.

Dr. Le Beuf read a paper on "*A Case of Cardiac Embolus, with Remarks* (see p. 575 this number of the Journal).

Discussion: Dr. McGehee had seen a similar case several years ago. The trained nurse had been the first to notice a discrepancy between the pulse and respiration. The patient had had a dry labor, uterine inertia made forceps necessary, and perineum was torn. Some blood lost. Perineum stitched. Nurse called attention to heart, which was then examined. A consultant was called, but diagnosis was not positively established. Woman very apprehensive. Enlargement of veins, especially in the neck, was a feature of the case. Pulsations very numerous. Breathing somewhat disturbed toward the last. Rapidity of the pulse increased until it was in the neighborhood of 160. Dr. Bickham, the consultant, advised absolute rest. Sleep was induced with bromides. Patient finally took up baby to nurse. Pulse never improved. Could account for symptoms on no other grounds than that patient had heart clot. Dr. McGehee rather inclined to the idea that these clots begin spontaneously in the heart. Had read of five cases, all following severe labor. Believes parturient woman's blood contains so much fibrin that clotting is favored, and that in these cases the heart fails to completely empty itself at each stroke. Advises stimulation before heart failure threatens, or defibrination of the blood beforehand, as by using non-albuminous foods.

Dr. Dupaquier quoted Charpentier, who, in a recent article on this subject, objects to the theory that excess of fibrin is responsible for these deaths. Dr. Dupaquier stated that the latest theory was that myocarditis existed in these cases, causing spasms of the coronary arteries. Had arrived too late to hear the paper read, but from a verbal account of the case, previously given him by Dr. LeBeuf, it seemed that the patient had suffered from typical attacks of angina pectoris. An embolus from uterus would usually be found in the pulmonary arteries.

Dr. Miller had had one similar case in hospital practice. Pulmonary thrombosis rather than cardiac the real cause of the trouble, although the thrombus might extend back into the heart.

Dr. Storck had read that mitral vegetations were a frequent cause of heart clots.

Dr. LeBeuf had found no indications of valvular disease in his patient.

Dr. Perkins had seen a number of white fibrinous clots in hearts at autopsies following death from causes not referable to the heart, which would seem to indicate that clots might exist without causing any marked symptoms. He had also heard of a case in the hospital in which sudden respiratory failure had followed after a severe operation. Patient died in a few hours, and autopsy showed pulmonary vessels filled with clots. In reply to Dr. Matas' question, had not seen the autopsy and was unable to say positively whether the case might not have been one of fat embolism.

Dr. Matas desired to call attention to the comparative rarity of the diagnosis of heart clot and pulmonary embolism in obstetric practice as compared with that of former years. The same observation might be made with even greater force of the almost total disappearance of air embolism which twenty or thirty years ago inspired the surgeon with profound anxiety in all operations in the vascular regions at the root of the neck. Fat embolism appears to have to some extent supplanted the dread of air embolism in surgical practice, more especially in the treatment of fractures—but this accident was also very rare, for he knew of no case of death from this cause reported in this city. The attention given by the classic surgical authors of the present day to the subject of air embolism is certainly very scant, and the same may be said of the comparatively little attention paid to heart clot by modern obstetric writers. There is doubtless good reason for this change of attitude upon the part of medical observers toward these two conditions, and the explanation must be sought in the almost total absence of reported cases in recent years. In twenty years of medical observation in this city, Dr. Matas had heard of no case of death from air embolism in surgical practice, and only of three or four cases of cardiac and pulmonary thrombosis or embolism as

complications of the puerperal state. These cases when they did occur produced a profound impression and usually found their way to medical discussion and journals, and the rarity of such reports is significant. Apart from experimental evidence which has shown that the conditions which bring about a fatal termination from air embolism are usually extremely difficult to realize in modern surgical or obstetric practice, it is probable that the greater ability of the modern practitioner to differentiate pathogenic states has led to a gradual elimination of many cases which at one time might have been readily ascribed to embolism or *thrombosis*.

It is comparatively easy to understand the formation of emboli and heart clots in pathologic states—especially septic conditions affecting the peri-uterine tissues, but it is certainly very improbable in the light of modern pathology that any such conditions ever arise in the normal puerperium. He knew of one very remarkable case in which the symptoms seemed to bear out the possibility of this occurrence. In this instance, apparently, a young, healthy primipara, who was the daughter of the accoucheur, suddenly expired a few hours after a perfectly normal labor. She complained of shortness of breath; had to be propped up in bed, became livid, and after a few spasmodic gasps fell back and died. "Heart clot" was given as the cause of death, but no autopsy was held. Dr. Matas finally called attention to the greater probability of emboli originating in the peri-uterine plexuses, finding their way to the pulmonary artery and the lungs, where they formed infacts rather than the formation of permanent heart clots, and again expressed grave doubts as to the spontaneous formation of either of these conditions ("heart clot" or "pulmonary embolus") in the puerperal state in the absence of well defined septic lesions of the vascular system.

Dr. Matas, in concluding, stated that he was inclined to accept Coste's views, mentioned by Dr. Dupaquier, regarding the cause of sudden and rapid death in childbed—that is, myocarditis, in other words, some degeneration of the myocardium.

Dr. LeBeuf, in closing the discussion, said he did not see how angina pectoris could have been diagnosed from the symptoms in his case. In thrombosis of the pulmonary arteries some pulmonary lesion usually existed. In this case there was no such lesion.

Dr. Scheppegrell, read a paper on "*Dust as a Factor in Diseases of the Upper Respiratory Passages.*" (To be published in the completed volume of Proceedings).

Discussion: Dr Matas, asked whether Dr. Scheppegrell had found any especially evil effects upon the upper air passages following the habitual inhalation of lint from cotton. In his own practice he had met a number of cotton men who believed that the dust of the cotton room was especially deleterious. He was inclined to consider the lint simply a mechanical irritant.

Dr. Martin was able to speak of the effects of cotton dust and lint from his own experience on a cotton plantation. In his youth he had often known the men employed about the gins to cough a great deal from the constant irritation of the lint and the fine dirt ginned out of the cotton, but he did not remember having heard of any permanent disease resulting.

Dr. Scheppegrell, in closing the discussion, stated that he had found cotton fibres in the nostrils and sometimes in the throats of cotton classers in his office, but that he considered the evil effects simply mechanical. The cotton had no specific effect.

The regular program having been completed, Dr. Miller read a paper on "*A Case of Supra-Vaginal Amputation of the Uterus for Fibroids Complicating Pregnancy.*" (See p. 581, this number of the Journal.) No discussion.

Dr. Storck reported the following case: John C. White, aged 5, taken severely ill with several violent convulsions and vomiting. Patient had a warm bath, inhalations of chloroform, whisky hypodermically, and hot bottles to the surface. Mustard and ipecac internally, and apomorphia, gr. $\frac{1}{10}$ by needle, failed to induce emesis. Pupils pin-point, reflex abolished. High enema given. After two hours of coma, patient had slight convulsion. Potassium bromide gr. xx, and chloral hydrate gr. viiss, given by rectum. Three hours more of coma. Pupils alternately dilated and contracted. Meningitis was considered as a possible explanation of symptoms, some preputial adhesions were found and broken. Another enema, saline, was given. Stomach washed out and mustard, syr. ipecac and mucus found in it, but no undigested food. A few hours before first convulsion, child had eaten a pork chop. Child finally rallied, and temperature, which had been 97 deg. when Dr. Storck first saw the patient, rose to 101 2-5 deg.

Dr. Barnett thought that a purgative would have been better treatment, as several hours after being eaten the chop was probably in the intestine.

Dr. Matas remarked that apomorphia acted as a very efficient hypnotic when it failed to produce emesis. Recent observers had found 1-30 gr. to be a prompt hypnotic, acting in ten minutes or less.

Dr. Asher had known of drowsiness following the administration of apomorphia.

Dr. Perkins had been impressed by the unilateral convulsions seen in a negro child who was brought to the hospital for treatment three or four times. Each attack was caused by the ingestion of large quantities of pork, cabbage, etc., and all the attacks were relieved by gastric lavage, enemata and cathartics.

Dr. Dabney had found unilateral spasm very common among children suffering with convulsions from indigestion. He habitually used apomorphia as a hypnotic in cases of delirum tremens. Had that day seen 1-16 gr. induce sleep in such a case.

Meeting March 9, 1901.

Dr. Feingold exhibited *three Cases of Ocular Disease.* (See p. 588, this Journal).

Discussion—Dr. E. W. Jones considered the first case to be undoubtedly one of opththalmia neonatorum.

Dr. Bruns believed the second case to be one of an atypical variety of phlyctenular ophthalmia peculiar to the negro, and not one of "spring catarrh," which is extremely rare on this continent. The "spring catarrh" of German authors is characterized by a "bacon fat" infiltration of the conjunctivæ bulbi as well as palpebral. Children and young adults most frequently affected, and the cases are worse in summer and better or well in winter. Although Dr. Feingold's case resembled one of "spring catarrh" in someof its features, Dr. Bruns hadseen many such cases among negroes, and was convinced of its phlyctenular character. The reason of the paucity of literature upon such conditions was that text-books on ocular diseases have been for the most part written by foreigners who are unfamiliar with the

pathologic peculiarities of the negro. In his 20 years of hospital practice in New Orleans the condition had been frequently observed in negroes, but not in whites. Old negroes are often affected, and the disease is as persistent in winter as in summer. Dr. Bruns had seen three cases this winter. Infiltration in some cases not encircling cornea, but encroaching from either side. In a large number of cases it is possible to see stages of the disease varying from a bad phlyctenule to conditions like that of Dr. Feingold's patient. The peculiar susceptibility of the negro to lymphatic diseases illustrated by frequency of phlyctenular ophthalmia among that race. In spite of the text-books, phlyctenular ophthalmia is not a disease of childhood especially, though negro children are more liable to it than adults. Adult whites rarely have phlyctenules. While phlyctenules in whites are easily cured, in the negro successive ulcerations often occur in spite of active treatment, and sometimes cause complete obscuration of the cornea. This form is to be treated as other phlyctenular manifestations, by mercurial stimulation of the lymphatics, using either the yellow oxide salve or calomel dusted in eyes. All phlyctenular affections more refractory in the negro than in whites. In conclusion, Dr. Bruns emphasized the necessity for text-books emanating from this section to properly treat of the pathologic conditions peculiar to it.

Dr. Feingold, in closing the discussion, called attention to the rarity of such a sequel to ophthalmia neonatorum, which ordinarily would cause rupture of cornea. The fact that the cornea in this case was scar-like without symptoms of ulcer, was the interesting feature. As to the second case, had been doubtful as to its classification, and had even considered conjunctivitis lymphatica as a possible diagnosis. Had watched the case for three weeks without treatment, but had observed no symptoms of ulcer. Had found case resistant to treatment. In conclusion urged the necessity for not allowing midwives to prescribe for ocular diseases of infants.

It was then moved and unanimously adopted that Dr. Bruns address the society upon the subject of legislation relative to midwives and ophthalmia neonatorum, as he had been especially interested in this matter.

Dr. Bruns said that the American Ophthalmological Society has a standing committee whose duty is to promote in

every State of the Union the passage of a law compelling midwives to call in a physician for every case of purulent disease of the eyes of the new-born. Some States have already adopted such laws. Some years ago Dr. Bruns had secured the introduction before the Louisiana Legislature of such a bill, endorsed by this society and by the State Board of Health, but it had been defeated. Dr. Bruns stated that of all blindness, the greater portion was due to ophthalmia neonatorum. This absolutely preventable disease is filling our blind asylums and causing numbers of people to become public or private burdens. The subject should be agitated from time to time until suitable laws are enrolled on our statute books. Crédé long ago demonstrated that the application of a 1 per cent. solution of silver nitrate to the eyes of all new-born would cause the disappearance from the world of ophthalmia neonatorum. All cases properly treated in the first few days are cured.

Dr. Gessner called attention to the fact that the State Board of Medical Examiners could be made to lay more stress upon ophthalmia neonatorum in determining the qualifications of midwives.

Dr. Gessner read a paper on *A Case of Atony of the Bladder.* (To appear in completed proceedings.)

Discussion: Dr. Le Beuf, when a student, had on one occasion been prevented from emptying his bladder for about twelve hours. His suffering was intense, and involuntary urination occurred immediately after his escape from social martyrdom. Vesical irritability ensued and blood was passed with urine for several days. Even now urination is somewhat abnormally frequent.

Dr. Parham remarked that Dr. Gessner had been peculiarly fortunate in the happy termination of the case related in his paper. Not infrequently such cases ended much less favorably, and the satisfactory outcome in this case must be largely attributed to the judicious treatment carried out. The last speaker was also to be congratulated upon his remarkable endurance, which had enabled him to withstand so successfully the effects of such prolonged distention of the bladder. Dr. Parham referred to the case of the well-known chemist, Wuertz, who had while traveling on a train in France allowed his bladder, through motives of modesty, to become distended for such a length of time that he subsequently died from the effects.

As an example of extreme distention, happily recovered from, he related the case of an old man of 79 years of age, a sufferer from enlarged prostate. The old man had been for a time under treatment, but becoming unruly, had refused to submit to further discipline and had left the private hospital and gone to his home in a deserted hotel of which he was custodian. He (the speaker) had received a call one evening and found his patient was this same old man. Finding another doctor had just been in attendance and seeing that something should be done at once for the already distended bladder, he went out in search of the doctor who lived close by. After some time he returned with the doctor but found the building, through some misunderstanding, shut up for the night. Dr. Parham met the doctor there in the morning, over twelve hours after the previous evening's visit. The bladder, not having been emptied at all, was, of course, enormously distended. He was at once hurried up to the Sanitarium where his bladder was opened above the pubic bone. This case was subsequently successfully operated upon by Bottini's method, the index finger introduced through the bladder opening materially assisting in holding the instrument in place. The case made a satisfactory recovery, for some months later he was able to empty his bladder voluntarily after several hours' holding of the urine. The recovery in such cases must be attributed to the free drainage and consequent absolute rest of the bladder, by means of the supra-pubic opening. We are sometimes called to cases where, especially after repeated unsuccessful attempts at catheterization, the urethral congestion is so great as to make any further attempt at entering the bladder by the urethra positively harmful. In such cases, in his opinion, it is far better to enter the bladder by means of a small trocar above the pubes. The effect of this is sometimes magical, the urethra being afterwards easily entered by a Nélaton catheter. Occasionally, the trocar must be used several times and now and then it may be best to leave a canula permanently in place. A case was recently admitted to his service in the hospital with a canula in place above the pubes. This had very properly been left in by the doctor who inserted it in an emergency, owing to closure of the urethra by a malignant growth.

Dr. Nelken mentioned a case of distention, the bladder almost reaching the umbilicus, in which the patient refused to

be catheterized because the constant dribbling seemed to him to prove that his bladder could not be full. An amusing incident had occurred at the Charity Hospital. A woman was transferred to a gynecologic ward, supposedly for a large abdominal cyst. Upon catheterization the cyst disappeared and 1½ gallons of urine were withdrawn.

Dr. Perkins related two cases illustrating how differently vesical distention might result. A policeman, on duty at a public festivity, although unable to leave his post to urinate, had succeeded in imbibing generously of beer. After something over twelve hours without urination, he applied for relief, complaining that urination was impossible. One catheterization sufficed. Evidently overdistention had caused a temporary paralysis. The second patient was a young man who, for one year, had been treating himself for supposed "gravel." When first seen he had passed no urine for over forty hours, and had been traveling with a full bladder. After repeated attempts, a Gouley catheter, No. 2, was finally passed over a filiform, and the bladder emptied and irrigated. For several days patient was instructed to sit in a tub of warm water for 10 or 15 minutes before attempting to urinate, and to do this regularly every four hours. No further catheterization was necessary, the bladder apparently not being paralyzed in spite of the prolonged distention. With the assistance of Dr. Parham, sounds were introduced, and the three urethral strictures which caused the obstruction were eventually dilated to 26 F. Patient declined further treatment.

Dr. Dabney had found it advisable in retention of urine to induce muscular relaxation with repeated doses of tartar emetic and morphin, $\frac{1}{16}$ grain each, at intervals of three hours.

Dr. C. H. Tebault, Jr., agreed with Dr. Dabney as to the value of emetics in some cases, and had himself used apomorphin hypodermically to induce relaxation.

Dr. Lazard's only objection to Dr. Gessner's treatment was that 90 grains of urotropin daily is excessive. Considered 7½ grains every 5 hours satisfactory. Even this quantity given in a maternity case in his own practice had caused the reappearance of albumin. Formalin, which is liberated from the urotropin, is a renal irritant.

Dr. Martin agreed with Dr. Parham as to the advisability of using the trocar, and considered the procedure perfectly safe when properly carried out.

Dr. LeBeuf and Dr. Bruns alluded to the late Dr. Miles' frequent use of the trocar for vesical distention.

Dr. Lemann had seen coma follow immediately after a trocar had been introduced above pubes, death ensuing in one hour.

Dr. Parham had seen a case in which 14 punctures had been made above pubes. He had succeeded in easily passing a Nélaton catheter. Rest had effected a cure. Had never seen any trouble follow the use of the trocar properly introduced and not too large. Should be introduced not too far above pubes, using the resistance of pubic attachments to steady the bladder. Should be introduced from time to time as needed, and not left in continuously.

Dr. Barnett spoke of case in which the bladder reached almost to the umbilicus and catheterization was impossible. After 4 or 5 punctures it was possible to introduce a number 18 sound through the urethra.

Dr. Gessner, in closing, thanked Dr. Lazard for calling his attention to the possibility of urotropin increasing amount of albumin already present in urine. Had been accustomed to use the drug in the doses mentioned. To emphasize the fact that too large trocar was dangerous he described a case in which the cavity had developed in the pre-vesical space after supra-pubic puncture with a large instrument. Sloughing occurred and death ensued.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

The Surgical Treatment of Hepatic Cirrhosis.—The almost hopeless prognosis in most cases of cirrhosis makes welcome any therapeutic suggestion based on sound principles.

To Talma, of Utrecht, belongs the credit of first suggesting the operative relief of cirrhosis by bringing about adhesions between the abdominal organs and the abdominal wall. After this, operations were done in Holland, by Van der Meule, in 1889, by Schelky, in 1891, and by Lens, in 1892, all fatal. Such results had their effect, for nothing more was done until Drummond and Morison, in England, in 1894 and 1895, operated on two cases, one being successful, the patient being alive and well two years later. To them must be given the credit of establishing the operation on a firm surgical basis, and their success gave a decided impetus to the surgical treatment of this disease of such hitherto deplorable prognosis. Cases have now sufficiently multiplied to permit of something like appraisement of the value of the procedure.

Two valuable articles have recently appeared, which present the subject in a very instructive way. One of these is that by Charles H. Frazier, in the December number, 1900, of the *American Journal of the Medical Sciences* and the other that by Packard and LeConte in the March number of the same publication. The latter publication tabulates all the cases the writers had been able to collect from medical literature. Taking all the cases recorded there was a total of twenty-two operations, the results of which may be stated in percentages as follows:

Immediate death	22.7 per cent.
Ultimate death	13.6 "
Unimproved	13.6 "
Improved	9.1 "
Recovered	40.9 "

By eliminating three cases done at a time when the operative technic was not as perfect as it is to-day, and a fourth case because the diagnosis of cirrhosis was doubtful, the number of cases is reduced to 18 and the percentage of recoveries raised to 50, the operative mortality being 16.6 per cent.

Further, leaving out cases 8, 10, 13 and 14, because complicated either by other pathologic conditions or by other simultaneous operations of gravity, there are remaining 14 cases, showing a percentage recovery of 64.3 and an operative mortality of 7.1.

"Contrasting the worst view with the best possible construc-

tion, we have the operative mortality lying somewhere between 23 and 7 per centum. When we remember that the cases subjected to operation had been for weeks or months under careful medical treatment and had been repeatedly tapped, and that their condition was unimproved or growing steadily worse, the above statistics are certainly very encouraging." In this view we can certainly concur.

Frazier concludes from his study of the subject that "in properly selected cases, and by that I mean (1) cases in which the liver is cirrhotic; (2) cases in which there is reason to believe the liver cells are not devoid of function; (3) cases in which internal medication (particularly iodide of potassium and paracentesis) fails to afford relief, or, in other words, in utterly hopeless cases, and (4) cases in which there is no reasonable contraindication—that in such carefully selected cases the operation has a future."

Packard and Le Conte conclude their article in the following words:

"*A priori* cases of cirrhosis of the liver stand injury badly, and therefore are poor subjects for operation. The resistance of their tissues is presumably much less than in health. The exact estimation of the amount of degeneration of the various organs, including the liver, is extremely difficult or impossible, consequently the mortality of the operation under consideration would naturally be expected to be relatively high. The statistics given above seem to show that the operation has won a distinct place and in the future a clearer conception of the suitability of particular cases for the operation may be possible. Without operation these patients as a class are doomed to a life of perpetual invalidism, requiring constant treatment and repeated tappings to make life bearable. It is our opinion that where the diagnosis of pure portal cirrhosis can be made, and where persistent and well directed medical treatment is productive of insignificant results, the operation should be strongly recommended. On the other hand, it would seem that the operation is scarcely indicated, if not contraindicated, in cases of ascites associated with other kinds of cirrhosis (Hanot's, syphilitic, mixed, etc.) or with chronic peritonitis."

Fracture of the Anterior Floor of the Skull, with Consequent Meningitis; Bilateral Trephining; Recovery. —Poirier in the *Revue de Chirurgie* (February 10, 1901), relates

the case of a man, 32 years of age, who fell his full length, on the right side of the head, and who afterwards presented signs of fracture of the anterior floor of the skull. He was admitted into the hospital, but deserted two days afterwards. He was obliged to return four days later with fever, and cerebral symptoms indicating meningo-encephalitis. To cut short this infectious complication, Mr. Poirier decided to make a rent on each side of the skull above the auditory meatus; this operation was performed with the chisel and mallet. A crucial incision was made in the dura-mater, through which flowed a reddish liquid, slightly sticky. The wound was drained and packed. No noteworthy post-operative results. On the following day the temperature dropped, excitability ceased, and the patient recovered. A bacteriologic examination of the evacuated fluid revealed the presence of the staphylococcus aureus.

Radiography in Penetrating Revolver Wounds of the Skull.—In *Revue de Chirurgie* (February 10, 1901) Mauclaire relates two cases in which revolver bullets were exactly located with the aid of Contremoulins' apparatus; one in the internal orbital wall; the other in the cerebral substance. Their removal was thus facilitated. Tuffier had five cases in which he employed Contremoulins' method, and in each had such precise and exact indications that he was able to go down directly on the bullet. This method seems to him far superior to all others.

Michaux also eulogises this method, having in one case, been able to realize its full value.

Mignon, although recognizing all the merit of Contremoulins' method, thinks that with the ordinary means of radiography one can sufficiently locate and find the bullet.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans.

The Surgical Treatment of Puerperal Sepsis.—*Obstetrics*, December 1900, contains an editorial on the above subject that so reflects the attitude of the practical surgeon of to-day that

it is quoted in full. It states in the beginning that the marked differences of view held by obstetricians and gynecologists as to the question of operative treatment of puerperal infection are in no way due to confusion over what may be the proper surgical procedure in a known pathologic process, but to a want of diagnosis. There might be no opposition to the question of hysterectomy for the uterine body and adnexa which are filled with many pockets of pus that can not properly drain into the cavity of the organ; nor for free puncture and drainage of purulent infiltrations of the broad ligaments and neighboring parts; nor to flushing and draining in certain conditions of peritonitis; but the worry of the profession at large is to know when these conditions exist. In truth, it is the worry of the operators, who would be leaders as well. The most remarkable feature of the present writings on this question is not what is said, but what is not said in the arguments brought forward.

Operate, yes; but when? In certain forms of infection speed is objectionable, *i. e.*, the infiltrating cellular variety; in another form delay is fatal to success, the foudroyant type, in which germs fly like winged messengers along the tracts of the lymphatics or veins. It is a very small per cent. of cases of puerperal infection that ever requires operation, therefore, it is a very small per cent. of cases on which we operate in which the diagnosis is actually made before the exploratory incision is made. We come, then, to the question of whether an exploratory incision in cases suspected of being in need of operative measures will be so free from danger as not to produce a greater mortality than occurs in cases treated by non-operative methods. This question is not being treated as fairly and impartially as it should be. There are numbers of physicians, more gynecologists than obstetricians who have had relatively little experience in treatment of infected cases by non-surgical measures, and have not, therefore, a proper sense of the conservative tendency of these cases to recovery, who discuss the needs of operation in isolated simple cases, and to the satisfaction of all in this respect, but who do not weigh the dangers from operation in their true balance against all cases. Nor are they all clear in determining how to make a diagnosis. To undertake to forestall the general distribution of streptococcic infection is most desirable, but are we to operate every time we think a case

is moving to such a form. Many cases so threatened do not become systemic and operation may increase the mortality, rather than reduce it. The obstetrician in a large hospital practice, who has every opportunity of observing cases in every form, has two views forced upon him, viz., that very few cases prove the need of operation, and that the argument of the bedside is strong for conservatism. The most crying need of the hour is for differential diagnosis. Examinations of the vagina, cervix and secretions of the uterus and vagina for exact bacteriologic knowledge of the infection when made promptly with the beginning of symptoms, will enable us to check many cases by direct local applications.

An exact knowledge of the character of the labor through which the patient passed will help in learning of actual conditions. Thus, some cases suggest the presence of thrombi in the sinuses because the patient had an exhaustive labor with hemorrhage from the placental site and final cessation of the bleeding through general circulatory weakness; or she had prolonged stasis of the fetal head at a given point which suggests possible necrosis of a small part of the uterus with underlying germ growth in the line of separation, or she had become very edematous before delivery, with dryness of the vagina and vulva, a condition for infection and its rapid extension; or she has had secondary postpartum bleedings with probable formation of blood clots in the cavity which may not be expelled until they have softened by decomposition. All such conditions indicate the lines of surgical treatment and are very helpful to diagnosis when known. There is a great field here for further investigation as to the individual behavior of the several germs which produce infection. Our present knowledge is very limited, considering the importance of the field. We need reports of a thousand cases of gonorrheal infection alone, of the streptococcic infection, and of each of the others, and also each of these in combinations, with extended studies of their characteristics. We will have such information ere long, for many obstetricians are accumulating such data. We have tried to conquer puerperal infection by a master stroke; we have tried to treat it specifically and all have failed us. We may find a specific, but our present duty and opportunity is to accumulate all possible data of exact reports of many cases of infection.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Sudden Death by Inhibition.—Sudden death often brings forth a matter most difficult of solution, as for instance, when knowing upon what occasion and under what circumstances death occurred, nothing is revealed by autopsy to account for it. Such is the case of a man who, in the very best of health, upon receiving a blow, say in the abdomen, dies suddenly, and no trace of injury at autopsy can be found. This is called *sudden death by inhibition*, in other words, by sudden arrest of both cardiac and respiratory functions in consequence of peripheral excitation. Poirault, in his recent thesis (Paris), has collected quite a number of facts illustrating how sudden death of such a kind occurs in the most unexpected circumstances. Some time ago we published several cases taken from Brouardel's book on the same subject. Here are some additional facts which, though exceptional, are likely to occur:—

Bar's case reported by Poirault. Sudden death following intra-uterine douche after a normal labor: Patient is taken with convulsive seizure, throwing up her arms in contracture, thumb flexed in palm, respiration stops. Then, followed five or six sudden jerks of diaphragm, like hiccough. Face cyanotic, pupils dilated. Artificial respiration in vain. Patient was dead. Autopsy revealed nothing.

Vibert's case of sudden death during vaginal douching: Woman found dead in her room, nozzle with tube attached to irrigating apparatus found between her thighs. Autopsy revealed pregnancy in early months, all organs were sound, including uterus.

Lorain's case of sudden death following vaginal injection: A young girl of 16 years, hymen intact, had caught gonorrhea. Lorain, himself, made careful injections into the hymen's opening with a small glass ear-syringe. Simple operation, devoid of trauma. During the fourth injection, the girl died suddenly.

Brouardel's case of sudden death following digital examination of vagina: In the service of Gosselin a woman lay on her

bed for a digital examination. This performed, as Gosselin was washing his hands, the woman died before Brouardel, who stood by the bed, could give her any efficient help. Autopsy revealed only a fibrous tumor of the uterus; all other organs were sound.

Hutmel's case of sudden death following a blow in the abdominal region. A female nurse, playing with others is violently pushed against a door, the knob of which strikes her abdomen. She died in a few minutes. Autopsy revealed only a marked relaxation of the vessels in all the organs.

Tardieu's case of sudden death following a blow on larynx: An old woman, a tobacco shop-keeper, was waiting on a youngster who had called for snuff. She had a prominent Adam's apple and the boy took a fancy of touching it and moving it up and down her neck, so he playfully made out as if he was trying to catch a fly and struck the old woman's thyroid. She died on the spot.

Maschka's case of sudden death following a blow on larynx: A little girl skylarking in the streets, is struck by a brickbat on the larynx and died immediately. No trace of injury found.

Pyl's case of sudden death following a cold drink: A man was quarrelling with a fellow-workman, and in the heat of anger, to cool himself, he gulped down a glass of beer. He dropped dead immediately. Coroner's report cleared the other party from accusation of poisoning as made by the dead man's widow. Pyl believes that death was due to sudden impression of cold.

Duncan's case of sudden death following a cold drink: A bookbinder in Edinburgh drank a large glassful of cold water, and was immediately after taken with pain in epigastrium and spasmodic vomiting. Death after twelve hours. Autopsy revealed no trace of lesions.

From the medico-legal viewpoint these facts are of moment. It must be admitted that individuals succumbing in this manner present a peculiar susceptibility aggravated by certain circumstances of which the chief one seems to be the period of digestion. It is almost impossible to hold anybody responsible for a trifling trauma, followed by such unexpected results, and in the case of physicians sued for damages when death followed an intra-uterine injection, for instance, experts most assuredly will put the question: Was there any blunder, neglect, unskilfulness, heedlessness on the physician's part? Autopsy with the

history of the circumstances accompanying death will suffice to exonerate the accused party.—*Journal de Médecine et de Chirurgie Pratiques, 25 Janv., 1901.*

Hysteric Pseudo-Appendicitis—Périer reports two cases illustrating how closely the symptoms of appendicitis can be simulated by hysteria. The patients were two little girls who had heard a good deal about appendicitis, so much so that they knew all the symptoms common to appendicitis cases, and both presented an attack of pseudo-appendicitis just as they could have presented an attack of hysteric coxalgia or of any of the divers maladies which hysteria does so closely simulate. Périer was so perplexed in the first case that he called in an expert surgeon in consultation, who advised operation as soon as the acute stage was passed. Sevestre called in, also, made a reserved diagnosis and questioned the necessity of operating. But the parents were uncertain, and called in three more surgeons. The opinion of the last one called in prevailed, and as he advised immediate surgical treatment, the child was operated upon. The able surgeon looked in vain for any abcess or trace of appendicitis; everything was normal. The abdomen was closed, and the child, after an uneventful recovery, was sent back to her home, and has never felt better in her life than since the operation.

The second case, almost similar, was not operated upon as the child's imposition was discovered in time.

The conclusion to be drawn from these and other well known cases of similar nature, is, that we must consider in making out a diagnosis of appendicitis the nervous elements acting as factors, and we must also accept the assertions of hysterical subjects regarding the sham symptoms of their illness, only after closely examining each one apart to make sure that we are not imposed upon.—*Ibid.*

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

The Treatment of Neuralgia by Acupuncture.—Sutherland (*Semaine Médicale*) reports the immediate relief of severe neu-

ralgic pains, and particularly that type of pain called lumbago, by a simple and almost painless procedure. He pinches up a fold of the skin directly overlying the point of suffering, and pierces it through and through with a needle, which is allowed to remain in place for from three to twenty minutes. The relief experienced, due no doubt to an irritation of the nervous terminals and a modification of the circulation, lasts for about ten hours.—*The Therapeutic Gazette.*

Some Facts in Regard to Hypodermoclysis.—"That its wide employment has again and again saved life can not be denied.

"Not only does it dilute toxic material in the body in cases of infectious diseases and other forms of poisoning than infection, but it causes the elimination of toxic materials by increasing the flow of urine, and in many instances, in this indirect manner, benefits the general genito-urinary tract by diluting the urine so that it is no longer irritating.

"It has been at various times somewhat abused—that is to say, it has been given to patients who were so ill that no good could be expected from its employment, and then when it failed to do good has had discredit cast upon it. Then, too, it has been abused, in that non-sterile apparatus has been employed, which has resulted in the production of local inflammation; and again, the salt solution has been poured so freely into the subcutaneous tissues that it has practically drowned the patient by being introduced faster than his emunctories could eliminate it. Finally, we know of instances in which the solution has been employed so hot, by a careless nurse, that a local slough has been produced; and again, of other cases in which the fluid was entirely too cold. Hypodermoclysis is not a method of treatment which can be hurried. The supply of fluid to the subcutaneous tissues ought never to be so free as to produce a huge swelling resembling a hematoma. While a certain amount of swelling necessarily comes from the extravasation of fluid, it ought at no time to be tense, and at no time so large as to indicate that the body can not absorb it almost as fast as it is poured in. Of course, in instances where the body is starved of blood because of hemorrhage, absorption takes place more rapidly on the part of the hungry blood-vessels than it takes place in a case of Bright's disease, when the subcutaneous injection is employed to dilute poison and to increase urinary flow.

"It has been recently suggested by Dr. Kemp, of New York, that in children often so small a quantity of liquid as one to two ounces of normal saline solution is sufficient, and that four ounces will often be of value in increasing the urinary flow in adults.

"The best place for the injection is probably in the lateral lumbar region, since this part is not well endowed with sensory nerves, the tissues are lax and can receive a considerable quantity of liquid, and should any local irritation ensue, the part is not pressed upon when the patient is lying in bed.

"It is not necessary, as a rule, to use water in the reservoir above 120 deg.; but the water, as it is delivered to the patient, should be from 105 deg. to 106 deg."

It should be recalled that these injections have a very wide clinical application. The following are some of the conditions which they are of value in meeting: Hemorrhage, surgical shock, toxemia from sepsis or any one of the infectious diseases, puerperal eclampsia, renal disease, diebetic coma, poisoning by the various vegetable alkaloids, snake poisoning, etc. In scarlet fever and diphtheria, and in certain cases of pneumonia with marked toxic symptoms, the injections are without doubt of very great value, as they are also in some cases of suppression of urine from etherization. The solution which is employed, modified from the formula of Ringer by Locke, can now be obtained in the form of "concentrated sterile saline," put up in ounce bottles, thoroughly sterilized and sealed, and of such strength that if the contents of one of these bottles is added to a liter of pure water, a normal saline solution is at once at hand. This is very much better than the use of saline tablets, which are often difficult to dissolve, and which not infrequently leave some sediment in the solution. Further than this, this mixture is very much better than the ordinary salt solution made with sodium chloride, or common salt, alone, in that it more closely approximates the normal serum of the blood. Recent physiologic researches published in the *American Journal of Physiology* indicate that solutions made of chloride of sodium alone are by no means as harmless as many persons have supposed. —*Ibid.*

TAPE WORM REMEDY—

℞ Male fern extract (ethereal) ..... 1½ drs.
Kamala powder ..... 2 drs.
Gum arabic mucilage ..... 2 drs.
Cinnamon water to make ..... 3 ozs.

Met. S. Half to be taken at bedtime, and the other half early in the morning.

—J. B. LAWSON, in *Glasgow Med. Jour.*

MODIFICATION OF MILK.—Dr. Townsend sums up as folllows:

1. The modification of cow's milk, with a knowledge of the percentage, is preferable to the guesswork feeding of infants.

2. Percentage feeding can be carried out by a milk laboratory or by home modifications.

3. Milk laboratories are unavailable to many by reason of their absence on account of the expense.

4. Laboratory modifications do not, in the experience of the writer, agree with infants as often as home modifications.

5. Laboratory modifications are necessarily subjected to more handling and transportations than home modifications.

6. Milk that is fresh, clean, and from cows free from tuberculosis is preferable uncooked, or in other words, pasteurization and sterilization, although sometimes essential, are to be avoided if possible.

7. The method of home modification and of calculating percentage should and can be made extremely simple, and such modifications are sufficiently accurate and uniform.

8. The addition of cereals to the milk, in the form of barley or oatmeal water, is generally advisable after the seventh month, and is desirable, before that age in some cases, as an aid to the digestibility of the milk.

—*Boston Medical and Surgical Journal.—Pediatrics.*

Department of the Ear, Nose and Throat.

In Charge of DR. A. W. DE ROALDES and DR. GORDON KING, New Orleans.

AN EXPLANATION OF THE CAUSE OF LARYNGEAL STENOSIS FOLLOWING TRACHEOTOMY.—E. J. Moure, of Bordeaux, in a communication to the Academy of Medicine of Paris, calls attention to

the frequency of laryngeal stenosis after tracheotomy, prohibiting the removal of the tracheal canula after the original acute stenosis has subsided. This annoying condition is especially encountered in young children where high tracheotomy has been performed and a tube worn for some days. In adolescents and adults this may also occur when the cricoid ring is divided. Stenosis remains then as a result of the arytenoid cartilages being forced together, and immobilization of their articulations taking place in a position to close the glottis. In children a subglottic inflammation is an additional cause of obstruction even when the cricoid ring is not severed. The author advises opening the trachea lower down and removal of the upper tube from the trachea.—*Revue Hebdomadaire de Laryngologie*, etc., December 29, 1900.

Deafness, Perversion of Taste, and Facial Paralysis Associated with Herpes.—A case of this nature was brought before the Otological Society of the United Kingdom by A. H. Cheatle.

Patient was a married women 27 years of age, gave no history of previous ear trouble or syphilitic infection, but gave evidence of the latter in some pigmented scars and an ulcer of the leg. A herpetic eruption appeared on anterior part of the neck, quickly followed by neuralgic pains in the region and tinnitus aurium and deafness in the right ear. Facial paralysis soon became apparent on that side, and the sense of taste became affected. A week later a severe attack of vertigo and vomiting came on lasting two days. No middle ear inflammation was present. The case was considered one of peripheral neuritis, probably due to grippe.

Use of the Tuning Fork as a Test for Disease of the Maxillary Antrum.—This method of testing the maxillary sinus for the presence of disease is advocated by Dr. D. A. Kuyk, of Richmond, Va., in an article appearing in the February number of the *Laryngoscope*. While the usual tests now in vogue may afford evidence leading one to suspect that the antrum is affected, nothing short of surgical exploration will give positive proof of existing empyema, and as those methods are painful and sometimes difficult, the author has sought to find a simpler procedure which will confirm the diagnosis.

When the symptoms and other tests by transillumination point to the antrum as the seat of an empyema, an ordinary tuning fork is made to vibrate and placed on the first or second molar tooth or over the anterior antral wall under the lip. If the antra are free and clear, the fork will be heard with equal distinctness and for a like duration over each side and in either location. If one antrum contains fluid the fork will only be heard faintly or not at all. A shadow over one antrum, as shown with the transilluminating lamp, may be due to a thickness of the bones, and in that case the perception of the tones of the tuning fork would not be diminished. This method has has been applied also to testing the frontal sinus.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

Section on Ophthalmology of College of Physicians of Philadelphia. At meeting of February 19, Dr. G. Oram Ring exhibited a young girl, 9 years of age, with Paresis of the Left Internal Rectus following Diphtheria, which, unlike most of the cases that he had seen, showed no improvement after nine months' time.

Dr. H. F. Hansell read a paper on Binocular Hemianopsia and Optic-Nerve Atrophy in a Case of Diabetes Mellitus. The patient, a woman, 56 years of age, had suffered for a number of years with diabetes mellitus. The eye symptoms commenced six months before she came to the Eye Department of Jefferson Hospital. The ophthalmoscope showed marked optic-nerve atrophy of each side without signs of previous papillitis. The perimetric measurements disclosed an irregular hemianopic field for white and a definitely outlined hemianopic field for colors. Vision had declined to $\frac{20}{200}$. Dr. Dercum, who saw the patient in consultation, believed that the diabetic and the optic-nerve atrophy were both due to the same cause, namely, intracranial lesion, probably of the floor of the fourth ventricle. The

urine contained ½ per cent. glucose and was of high specific gravity; it was free from albumin. The case is of interest in that it demonstrated the rare form of eye complication, namely, optic atrophy with hemianopsia without opacity of the media or history of inflammation. Dr. Hansell reviewed the recent literature.

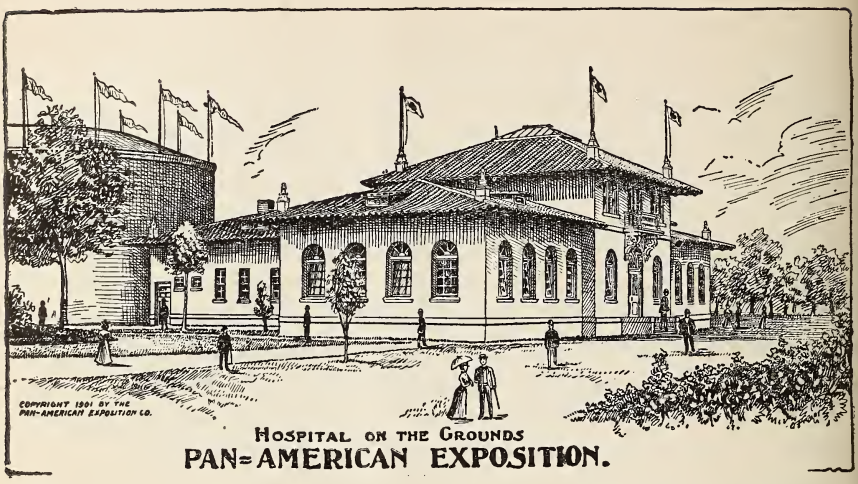
Discussion.—Dr. de Schweinitz thought that the symmetric changes in the visual fields in diabetes mellitus might be explained by the action of the toxin of this disease on the ganglionic cells of the retina. The degeneration in the ganglionic cells results in atrophy of the macular fibers, which later spreads to other bundles. The action of the toxin of diabetes under these circumstances is similar to that of certain drugs; for example, quinin, filix mas, methyl alcohol, etc.

Miscellaneous.

Emergency Hospital at the Pan American Exposition.—A very pretty hospital building stands near the west end of the Mall. Floor area rather than elevation is a prominent feature in the construction of this important adjunct to the Exposition. Color, here as everywhere throughout the grounds, adds its mantle of beauty to the odd and in many cases obsolete methods of construction, penetrating, rather than clothing, the building in the warm changing tints of the sunset. A low wandering adobe mission house covered with heavy red tiling, its weather stains retouched by the gorgeous rays of the departing sun, may be readily imagined while looking at this rehabilitation of the past.

Any antiquated illusion that may be conveyed by the outside appearance of this building is, however, at once dispelled by a visit to the interior.

Modern arrangements that are both convenient and sanitary mark every feature. Approved medical and surgical appliances have been carefully selected in regard especially for their adaptibility to emergency work and the exigencies that are likely to arise.



HOSPITAL ON THE GROUNDS
PAN-AMERICAN EXPOSITION.

The main office is situated at the farther left hand corner of this rotunda, where it is carefully tucked away under the staircase forming an irregular alcove. It contains telephone and electric annunciator, and messenger call service, with other modern and necessary appurtenances. As this is lighted from above and encircled by a round gallery opening through the upper story the effect is very pleasant and agreeable. The first floor front contains in the extreme western wing, two male wards with seven cots each, a bath room, physicians' office, a morgue and a linen chest. The eastern wing contains a woman's ward, large enough to hold a dozen cots, with direct communication to the woman's bath room. This wing also contains an office for the superintendent of nurses, private physician's office, a linen closet and other conveniences.

The upper story is intended for the use of the resident physician and the necessary attendants. The rear wing contains the operating room, sterilizing department and instrument cases. Immediately across the hall is the emergency bath room and patients' waiting room. Still farther down the corridor is located the kitchen, pantry and dining room. In addition to the two electric ambulances, a steam or gasolin motor ambulance will be provided to be ready in case of a possible failure of the electric current. The building is provided with natural gas for heating purposes and for cooking when necessary for the patients.

In the matter of equipment and appliances, everything is of the newest and best. In regard to the importance of this adjunct to the Exposition it may be said that up to the first of March, five hundred and four cases have been treated on the grounds, only one of which proved fatal. These include all forms of sickness and accidents to workmen employed upon the construction work.—HERBERT SHEARER.

THE ROLE OF PETROLEUM IN THERAPEUTICS AND WHY IT IS PRESCRIBED.—[Synopsis of research experiments made by G. Burbridge White, M. D., Diplomate State Medicine, University Dublin, F. R. C. S. I., Etc.]—Petroleum has of late become a most popular remedy. It is a comparatively new drug and not much information has been forthcoming respecting its therapeutic action. That which has been available has been somewhat confused and misleading. I may be able to throw some light on the subject by the brief remarks which follow.

The name, oil of petroleum, may convey the idea to the average medical reader that it is a fluid fat having all the characteristics of a fat and behaving like one when swallowed and subjected to digestive action, and the most likely fat for it to be confounded with is the well known cod liver oil. This error may be accentuated by the fact that both substances are to be found in the form of emulsion, about the same strength, and it is frequently stated that petroleum is a substitute for cod liver oil. If we examine the chemical and physical characters of these two substances we ought not to again confound them. Cod liver oil is a true fat, consisting chiefly of olein, containing an active principle termed morrhuol, and traces of I. Br. with phosphates, etc. It behaves like a fat when digested, being emulsified, partly saponified, absorbed to be assimilated, and enters into the body metabolism, the great objection to its use being that while undergoing digestion the fatty acids are set free and cause the usual eructations; also its smell produces nausea. It is not a good vehicle, as it soon becomes rancid. Furthermore, it offers concentrated nourishment for bacteria, and therefore serves as a culture medium for the growth and multiplication of micro-organisms, thus producing gastric and intestinal fermentation and auto-intoxication from absorption of toxins from the intestinal tract. Petroleum, the abso-

lutely pure residue after complete purification of the crude substance, is a fluid hydrocarbon, not a fat or oil, the formula C. Hn. representing a type of the series. It is devoid of chemical substances or salts in solution, can not be digested nor assimilated, nor can it enter the body metabolism. It is unchangeable, organisms will not grow in it, and it does not become rancid. Therein lies its superiority as a vehicle over perhaps any other substance used for this purpose. That it is capable of producing great clinical benefit can not be denied. I now proceed to point out how it acts.

Besides acting as an ideal vehicle, petroleum rivals belladonna in its numerous applications and therapeutic actions. It has been largely recorded of it that it increases weight, relieves dyspepsia, flatulence and constipation without aperients, diminishes cough, catarrh of the mucous membranes of the respiratory, intestinal and genito-urinary tracts.

In some experiments I made with Angier's petroleum emulsion upon digestion and absorption, I satisfied myself of the following effects. I found that certain proportions of the emulsion rendered peptones and fats (chyle) more miscible and diffusible, and that a quicker and more complete absorption of the weight-giving nutrients took place in a given time under its influence. This effect was enhanced by solution of thick impure mucus covering the wall of the bowel, while increased peristaltic action favored digestion, and also prevented constantly new and fresh portions of the finished products of digestion and absorption, while as additional action it was proved that the emulsion is a perfect intestinal antiseptic inasmuch as it completely inhibited the growth and action of purefactive bacteria such as inhabit the alimentary canal. Peptic and tryptic digestion was hastened and rendered more complete.

To put the matter shortly, petroleum properly purified and prepared is a substance that renders the digestion of all classes of food stuffs—albuminoids, carbohydrates and fats—more thorough than occurs without petroleum, and favors the complete absorption of the finished products of digestion into the system. It thus acts as a true nutrient, providing the tissues with exactly the character of material required to repair waste, and by thus maintaining normal nutrition it antagonizes the progress of morbid processes, such as tuberculosis, scrofula, inani-

tion, marasmus, etc. Furthermore, this emulsion was found by actual experiments to exert a more promptly beneficial influence upon inflammatory conditions of the respiratory tract than any combinations of expectorants and cough sedatives. It exerts this influence without inducing gastric disturbances of any kind; indeed it was noted that these disturbances when present as a complication of the disease were invariably overcome and the processes of digestion reinforced to a most pronounced extent. In pulmonary tuberculosis and in both acute and chronic bronchitis, not only was the cough rendered less severe and less frequent, but expectoration of retained secretions was easy and free from effort on the part of the patient. The symptoms of catarrh of the respiratory organs promptly disappeared and proved that Angier's emulsion has a sedative action upon the larynx, bronchi and pulmonary alveoli. In all cases the disappearance of the local symptoms was accompanied by improvement in nutrition, manifested by increase of appetite, ability to digest and assimilate food and a rapid and progressive increase in body weight.

Local Anesthesia in Hemorrhoidal Operations and all Varieties of Minor Surgical Work.—Dr. O. W. Green, in the *Medical Times and Register* for February, 1901, says: "Since there are so many people suffering more or less with hemorrhoids, and since orificial operations along that line have been performed only under general anesthesia, we desire to call attention to the fact that we have formulated a method by which hemorrhoidal operations are painlessly performed without the aid of general anesthesia. The operations are rendered painless by using the local anesthetic *acestoria*.

"Our method of operating on hemorrhoidal tumors is as follows: First, the patient is instructed to take a cathartic the night before the operation, and an enema in the morning. With a saturated solution of boracic acid thoroughly cleanse the rectum, using a syringe or otherwise, and then immediately inject every tumor in sight with acestoria until each tumor is not sensitive to the prick of the needle. Sometimes it is best to use the bivalve speculum before, sometimes after injection, and sometimes not at all. It depends upon the condition and location of the piles.

"With hemorrhoidal forceps, or Péan's artery forceps, pick up each tumor at its center, and turn it out.

"We generally use the clamp method when possible. Use Kelsey's or Pratt's clamp. After turning the tumors slightly outward with the forceps which were left hanging to them, each by turn is clamped at its base.

Then with a straight needle put in two or more stitches, as may be needed, back of clamp.

Remove clamp and cut tumor with straight scissors through the white line made by the middle blade of the clamp There will be no hemorrhage if this line is followed. The stitches are now tied. Each tumor is thus treated. Then with hydrozone and hot water, one part of the former to five of the latter, syringe or spray the field of operation thoroughly.

The object of using the hydrozone is two fold: It is the safest and best germicide and hemostatic we have yet used, and we have tried many. Not being a poison, and depending upon the oxygen it contains for its action, renders it safe under all circumstances, both externally and internally.

As a dressing we have several times used nothing, simply cleansing with hot water and hydrozone.

An ideal dressing is ordinary sterilized gauze moistened with glycozone. Glycozone is anhydrous glycerin saturated with ozone, a powerful germicide and promoter of healthy granulation.

To prevent pain usually caused by the prick of the hypodermic needle, touch the point chosen for insertion with a glass pointed rod, dipped into 95 per cent. carbolic acid.

To anesthetize the ear and stop earache, incline the patient's head to one side and drop into the ear about five drops of acestoria, or sufficient to fill the external meatus.

A New and Tolerable Form of Administering Mercury in the Treatment of Syphilis.—Dr. Winfield Ayres, in the *Philadelphia Medical Journal*, November 10, 1900, states that when his attention was called to mercurol as an antiseptic of special value in the treatment of gonorrhea, it occurred to him that it would be a first-class preparation for the treatment of syphilis. Some time was necessarily spent in determining the proper dosage. At first, one-eighth of a grain was given three times daily, and this dose was gradually increased until it was found that three grains was the average quantity required to control the malady. The highest amount given was seven grains, and the lowest amount that exerted a controlling influence upon

the disease, was one-half grain. In starting a patient on a course of mercurol, the author advises beginning with half grain or grain doses. Salivation has been produced by two grains, and yet as much as six grains has been taken with no disagreeable symptoms.

Mercurol is a nucleid of mercury, and was discovered by Karl Schwickerath of Bonn, Germany. Kopp, director of the Royal Polyclinic for Genito-Urinary Diseases at the University of Munich, uses mercurol in smaller doses, which leads the writer to remark "he will find as I have done, that it is desirable to use a much larger dosage." Mercurol should not be given in solution with potassium iodide.

In all, 65 cases received mercurol at the Bellevue clinic, 60 of which had not had previous treatment. Of these, 13 did not return after the first or second visit; 14 did not remain long enough under treatment to give the preparation a fair trial; and 13 may be described as new patients. Deducting these 40 cases, there remain 25 cases that have been sufficiently long and regular in their attendance to supply data from which definite conclusions may be deducted. The detailed histories of these 25 cases are included in the paper. In summarizing, the author remarks that while two months' treatment of syphilis is insufficient to determine absolutely the value of any remedy, the marked improvement shown by many of his cases makes it certain that mercurol is of great value. Its superiority to mercuric chloride in controlling the symptoms of syphilis is proved. Like all internal remedies, it has very little effect upon the initial lesion; still it has hastened the healing slightly. None of the cases required treatment with potassium iodide to control secondary manifestations.

To recapitulate: (1) Mercurol causes less disturbance of the gastro-intestinal tract than any other preparation of mercury used internally. (2) It controls skin eruptions and pains much better than any other preparation, while it controls mucous eruptions as well as any other, and has equally as good an effect upon the chancre. (3) It is an advantage that it can be taken in pill form.

PROTARGOL.—Having passed the experimental stage it may now be safely asserted, on the ground of the remarkably extensive literature published, that protargol is one of the most important additions to the materia medica of recent years. Aside

from its general use in the treatment of gonorrheal affections, it has, to a great extent, displaced nitrate of silver in diseases of the eye, ear, nose and throat. To obtain uniformly good results attention has been lately drawn to the importance of exercising proper care in making the solutions, a point which has been especially emphasized by Professor Neisser. A clear and satisfactory solution can be secured in any one of the following ways: Stir the protargol powder into a thick and smooth paste with a little cold water, and then add the bulk of the fluid. This should be done in a glass or china vessel, using a glass rod; if in a mortar, the latter as well as the pestle should be slightly moistened with a few drops of glycerin. Protargol may also be readily dissolved by dusting the powder evenly upon the surface of the water and allowing the fluid to stand without stirring for about ten minutes. It is very essential that only *cold* water should be used in making the solutions, as with warm water the drug is to some extent decomposed, and then becomes less active and may cause irritation; for the same reason the solutions should be preserved in dark colored, yellow bottles. In acute gonorrhea the average strength of the solutions ranges from one to ten grains to the ounce; in chronic urethritis, up to thirty grains; in diseases of the eyes, ears, nose and throat, ten to sixty grains; as an application to wounds and ulcers, one to two per cent. solutions and five per cent. ointments are in use. Unlike nitrate of silver, protargol does not stain the skin, even in concentrated solution. The solutions commonly employed in gonorrhea also do not produce stains of the clothing, or if they do, only cause slight discoloration, which can be easily removed with warm soap water. The much stronger solutions of twenty to fifty per cent. sometimes leave behind brownish-yellow stains on the clothing; if recent, they can be removed with soda and ammonia; if old, by the action of peroxide of hydrogen in the presence of ammonia.

Louisiana State Medical Society Notes.

Meeting of the Society, Thursday, Friday and Saturday, April 18, 19 and 20, 1901, at the Tulane Medical Department, Canal and Villere streets. Titles of papers not already an-

nounced must be sent to the committee of arrangements by April 6 to appear in the program.

A Preliminary Program has been issued to each member. In addition to the section discussions, miscellaneous papers have been arranged, as the program will show.

Every Effort is Being Made to have a large attendance at the coming meeting, and it is hoped that country members will help to make this the banner year. A number of instructive and timely discussions are promised, and the program promises to be unusually attractive.

Members of the Society Contributing Papers to the Society are reminded that the Journal will be pleased to publish these if they are not sent to other journals, and that as, the official organ of the Society, this Journal should be offered all manuscript first.

The Secretary will sell a copy of 1900 transactions to any person, non-member, at $1.

The Annual Address will be Delivered by Prof. Geo. E. Beyer, of Tulane University.

List of Subjects for Discussion and Papers to be Read at the Coming Meeting.

Sections.

Surgery.—Treatment of Fractures of Long Bones of the Upper and Lower Extremities.

Genito-Urinary Surgery.—Treatment of Cystitis.

Materia Medica and Therapeutics.—Is the Tendency Toward Prescribing Proprietary Medicines Increasing? Its Final Effect Upon the Profession of Medicine and Pharmacy.

Otology, Laryngology and Rhinology.—The Middle Ear Inflammations of Childhood and their Consequences.

A symposium on the above subject has been arranged and the following division of the subject has been decided upon: General Remarks, Relation to Deafmutisum and Causes—Dr. Gordon King; Pathology and Bacteriology—Dr. O. L. Pothier; Middle

Ear Inflammations Arising from General Infections—Dr. E. D. Fenner; General Infections Arising from Middle Ear Inflamations—Dr. J. B. Elliott, Sr.; Symptoms and Treatment of Acute and Chronic Middle Ear Inflammations—Dr. J. P. O'Kelley; Surgical Treatment of Complications—Dr. A. McShane.

Ophthalmology.—When Not to Operate in Anomalies of the Extrinsic Muscles of the Eye.

Oral Surgery.—The Care of Children's Teeth.

Neurology, Including Mental Diseases.—Alcohol in Its Relation to Nervous Diseases.

Quarantine.—The Period of Incubation of Yellow Fever (Dr. J. N. Thomas, chairman of Section, Quarantine, La.)

Sanitary Science.—Prevention of Spread of Contagious Diseases. (Dr. E. Souchon, chairman of the Section, urges all health officers to attend the meeting and participate in the discussion.)

Dermatology.—Dandruff.

General Medicine.—Scarlet Fever.

Medical Jurisprudence.—Board of Lunacy, with Special Reference to the Examination of Patients for Commitment in the Insane Asylum.

Obstetrics and Gynecology.—Lacerations of the Cervix and Their Consequences.

Diseases of Children.—Subject not announced.

Bacteriology.—Subject not announced.

Anatomy and Physiology.—Subject not announced.

Miscellaneous Papers.—1. Over Action of the Heart from Hyoscin, Dr. Parsons, of Minden.

2. Thirty Cases of Lobar Pnemonia with 29 recoveries, Dr. E. D. Newell, St. Joseph.

3. Otitis Media Neonatorum, Dr. O. Joachim, New Orleans.

4. Affections of the Nose and Throat as Factors in Diseases of Bronchi and Lungs, Dr. W. Scheppegrell, New Orleans.

5. Uses of Strychnin, Dr. J. M. Bonner, Delhi.

6. Uses of Potassium Iodide and Mercury Bichloride in Syphilis in the Negro, Dr. A. Guilbeau, Breaux Bridge.

7. Clinical Test of Sodium Cacodylate, Dr. E. M. Dupaquier, New Orleans.

8. The Effects of Alcohol on Digestion, Dr. J. A. Storck, New Orleans.

9. Vital Statistics in Louisiana, Dr. G. Farrar Patton, New Orleans.

10. Science and Pseudo-Science in Medicine, Dr. T. S. Dabney, New Orleans.

11. Symptoms of Extra Uterine Pregnancy, Dr. C. J. Miller, New Orleans.

12. First Help in Cases of Contagious Diseases, Dr. C. L. Horton, New Orleans.

13. Ptomain Poisoning in Children, Dr. L. G. LeBeuf, New Orleans.

14. Dermoid Cyst of the Scalp with Report of a Case; Spinal Analgesia, by Dr. S. P. Delaup, New Orleans.

15. Spinal Subarachnoid Injections, by Dr. F. W. Parham, New Orleans.

16. An Unusual Case, by Dr. C. J. Ducoté, Cottonport, La.

Medical News Items.

The Orleans Parish Medical Society passed resolutions on February 23 urging the need of a City ordinance prohibiting spitting on the floors in public halls or public places of amusement.

The sum of $25 was donated to the $1000 fund being raised in the United States as the contribution to the amount needed to erect a bronze statue of Prof. Ollier, in the City of Lyons, France. The members of the Society have additionally subscribed to the fund so that New Orleans will have added its full equivalent to the amount to be raised in this country.

If the remarkable reports of Drs. Reed, Carroll and Agramonte are confirmed, the mosquito is the greatest foe mankind seems to have yet discovered. With malaria and yellow fever to condemn them, the culicides of the future should become as rare as buffaloes.

Tulane inaugurated Dr. E. A. Alderman as President of the University on Tuesday, March 12. Besides the members of the Tulane Board of Administrators and the Faculty, there were present the president of the N. O. Polyclinic, members of the School Board and other local educational institutions. The congratulatory addresses were delivered by Prof. Brown Ayres of Tulane, Pres. W. R. Harper of Chicago University and Prof. Nicholas F. Butler of Columbia University. The address of acceptance of Dr. Alderman was broad and scholarly, and, perhaps best of all, far reaching in its practical suggestions.

The Tulane Theatre, where the function was held, was packed with an interested audience.

Founders' Day of the Tulane University was celebrated March 13, and the whole day was spent by the students of the several departments in an inspection of the different divisions of the University; in the evening, addresses, a reception and dancing followed.

The New Orleans Polyclinic reached a total attendance of 140 physicians, March 29. The success of the present session has caused the faculty to extend the course to May 31.

The Medical Department of Tulane will hold its commencement exercises the first week in May. Vacation classes for students of this department are announced by some of the instructors and lecturers.

The Colorado State Medical Society offers a Prize of $25 for the best essay deemed worthy of such prize, pointing out the dangers to public health and morals, especially of young persons, from quackery as promulgated by public advertisements.

The competition is open to all. Essays must be typewritten in English and submitted before May 15, 1901. Each essay must be designated by a motto, accompanied by a sealed envelope bearing the same motto and enclosing name and address of the author. The essay receiving the prize will become the property of the Society for publication. Others will be returned on application. Essays should be sent to the Literature Committee, Room 315 McPhee Building, Denver, Colorado.

Rattlesnake venom is being used by Dr. DeMoura, at St. Paulo, Brazil, in the treatment of leprosy. The method employed aims at the use of gradually increasing doses of the venom protected by the use of an antidotal serum injected at the same time. The treatment is yet in the experimental stage.

In the same line the United States Army laboratory in Manila, Philippine Islands, is using Calmette's anti-venomous serum for the treatment of this disease, according to the suggestions made in 1897 by Dr. Dyer, of New Orleans.

Dr. L. D. Hill, of Austin, Texas, in charge of the Texas Confederate Home, and a graduate of the University of Louisiana in 1853, renews his subscription and congratulates the Journal on its success.

Dr. N. K. Vance has removed from Baton Rouge to Shreveport.

The Texas Medical Gazette, of Fort Worth, Texas, is a new journal that made its appearance January, 1901. Its editorial staff is composed of the members of the Medical Faculty of Fort Worth University. The Gazette has a good appearance, and we wish it success.

Dr. D. C. Gilman, who has been president of Johns Hopkins University since its inception, has resigned.

The University Medical Magazine is now the *University of Pennsylvania Medical Bulletin*. In future it is to be edited and maintained by the Medical and allied Departments of the University. All advertising has been eliminated from its columns.

In Indiana a regular licensed physician, who removes his residence to another county, must obtain a license from the clerk of that county, or he can not recover payment for his professional services.

Three New Orleans Physicians presented papers at the Pan-American Medical Congress in Havana: Drs. A. W. De Roaldes, Gordon King and A. Hava.

Dr. W. G. Kiger, of Brunswick, Miss., Ex-President of the Mississippi State Medical Society, and one of the most active members of the profession, was in New Orleans recently.

A Special Pan-American Congress will be held in Cuba in 1902, devoted exclusively to the consideration of Yellow Fever.

Dr. A. S. Warwick, who was at the Eye, Ear, Nose and Throat Hospital for more than a year, has located at Birmingham, Alabama.

Drs. J. C. Allen, and L. E. Morgan, have been appointed members of the Baton Rouge Board of Health.

The Alabama Medical Association will meet at Selma, April 16-19. The meeting promises to be well attended.

Obituary.

Dr. Paul von Seydewitz died March 15 in the city of New Orleans, at the age of 73.

The medical profession of New Orleans and not a few in the State of Louisana will remember the earnest interest which the subject of this sketch at all times evinced in professional affairs. No function of local or State association was ever complete without him, and perhaps no greater standard of comparison could be ventured than his punctiliousness in his relations to medical men. As the occasional collaborator of the Journal in its foreign translations, the Doctor came closely in touch with the editors, and if in no other way we owe a word to his passing.

His own silence regarding his past in itself compels our treating of him as we knew him. Erudite, polyglot, gentle, sympathetic, alive to any question of the moment and the hour, Seydewitz, as he liked his intimates to call him, was an unconscious factor in leavening the spirit of fraternity which now obtains here. His habits were solitary and his friends on that account few. Yet when occasion offered he was approachable and ever ready to be friendly and entertaining. Even when his loquaciousness seemed a burden to those who knew him least, there was a note of learning and of art in what he had to say. In his

pride and bearing even at the last, when disease and failing strength predicated the finale, he carried his head high and bore suffering with a Spartan's sense of honor. The Orleans Parish Medical Society owed him a debt which it has paid in rendering to him the last rites of burial and of honor.

When all is said, we have to add as we note his going that his was a mind, and perhaps a soul, misplaced among surroundings foreign to the talent which, had it room to blossom, would have shown the sort of glory which men with lesser minds have reached and gathered profit from. ISADORE DYER.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

The Eye, Ear, Nose and Throat. By WM. L. BALLENGER, M. D., and A. G. WIPPEN, M. D., Chicago. Lea Brothers & Co., Philadelphia and New York, 1901.

This work is one of a series of pocket text-books edited by B. B. Gallaudet, M. D., for the special use of students and general practitioners. While lacking in the important groundwork, the descriptive anatomy of the special organs, it is as complete in other respects as can be expected of a book of this kind, destined to afford a brief and concise study of the pathology and treatment of diseases affecting the eye, ear, nose and throat. Special attention has been given to the study of those special diseases that may lead to complications and effect longevity and due importance given to such conditions as nasal obstruction, sinus affections, etc., the influence of which on the general economy is so often overlooked.

DE ROALDES & KING.

The Year Book of the Nose, Throat and Ear. By G. P. HEAD, M. D., AND ALBERT H. ANDREWS, M. D., Chicago. The Year Book Publishers. Chicago. 1901.

This work has already become known as a valuable reference book in the specialty of the Ear, Nose and Throat, containing as it does abstracts of all the literature published during the past year which has been productive of new ideas and improved methods in the study of these special

organs. The editors have not only been active in culling the literature for original matter but have themselves added some valuable points of interest to the text. For the busy practitioner the book fulfills a useful mission.

DE ROALDES AND KING.

Rhinology, Laryngology and Otology, and their Significance in General Medicine. By E. P. FRIEDRICH, M. D., Leipzig. Translated by H. HOLBROOK CURTIS, M. D., New York. W. B. Saunders & Co., Philadelphia and London, 1901.

There is an unfortunate tendency among many specialists in the practice of their profession to take a too narrow view of the diseases brought to their attention, and they are prone to overlook the general constitutional conditions that are so often the underlying cause of pathologic disturbances in the special organs, and without a proper recognition of which local treatment is merely paliative to say the least. Hitherto the connecting link between the daughter and the mother science has been but poorly welded, and it has been the author's laudable purpose to point out more clearly and definitely the close interdependence between the diseased conditions of the general organism and those evident in the nose, pharynx, larynx and ear, and thus to elicit the interest both of the general practitioner and the specialist in this important line of study. The scope for close study and investigation here is as yet unlimited, but the author has produced a masterful work, and the book represents one of the most valuable additions to medical literature. The information furnished is based upon facts well established, and is devoid of theoretic speculation. All general diseases are treated of that bear the slightest relation to the special organs under consideration and their local manifestations closely studied. The work comprises 335 pages of solid text.

DE ROALDES & KING.

Diseases of the Heart, Their Diagnosis and Treatment. BY ALBERT ABRAMS, A. M. M. D. (Heidelberg), etc., G. P. Engelhard & Company, Chicago, 1900.

This little book is one of the publishers' standard monograph series, the very type of books we want. From the first to the last page there is not a word *de trop*. Every point is direct and practical. The author's original researches on lung gymnastics, heart reflex, tonometry and stethophonometry are clearly exposed in a few lines. Not only the arrangement of the subject, but the conciseness of the author's remarks are attractive. The book is neat, the paper and print are remarkably pleasing, so that any reader will be taken up with the whole of the work.

DUPAQUIER.

A Practical Treatise on Materia Medica and Therapeutics, with Reference to the Clinical Application of Drugs. By JOHN V. SHOEMAKER, M. D., LL. D. Fifth Edition Thoroughly Revised, Student's Edition. F. A. Davis Co., Philadelphia, 1900.

Dr. Shoemaker has altered his original plan of publishing his work in two connected volumes, and now proposes to issue separately a Student's and a Physician's Edition.

We heartily endorse Dr. Shoemaker's plan in the student's edition of treating only the official remedies in the pharmacopeias of the United States and Great Britain. In this manner, the study and application of legitimate drugs will be encouraged, and we shall await with interest the outcome of Dr. Shoemaker's venture.

In this edition, the metric system of weights and measures is used together with their equivalents in the English system.

After a careful perusal of this work, we are convinced that for the use of the student it is one of the best of its kind extant. STORCK.

Modern Medicine. By JULIUS L. SALINGER, M. D., and FREDERICK J. KALTEYER, M. D. W. B. Saunders & Co., Philadelphia and London, 1900.

It has been the aim of the author to combine in one volume, in brief form, a study of the special subjects, such as: Physical diagnosis, bacteriology, the examination of the gastric contents, the urine, the blood, the feces, etc., as applied to clinical medicine.

Under the examination of the stomach contents, the author fails to make mention of Töpper's reagent, dimethylamidoazobenzol, as a test for free hydrochloric acid. This is unfortunate, as this substance is conceded by chemists to be the most delicate of all known reagents for the detection of free hydrochloric acid in the gastric juice.

In the article on leprosy, under treatment, we notice that no mention is made of antivenene or potassium chlorate, both of which have been successfully used by Dr. Isadore Dyer.

The arrangement of the book appeals to us as being excellent, and, with a few corrections, we think it will prove a great convenience to the busy practitioner. STORCK.

A Text-Book of the Practice of Medicine. By JAMES M. ANDERS, M. D., LL. D. Third Edition, revised. W. B. Saunders & Co., Philadelphia and London, 1901.

This edition of Dr. Anders' contains some important alterations and additions. Among the new subjects, we notice Glandular Fever, Etherpneumonia, Splenic Anemia, Meralgia Paræsthetica and Periodic Paralysis. Among the articles which have been revised, or rewritten are: The Plague, Malta Fever, Diseases of the Thymus Gland, the Liver Cirrhoses, Progressive Spinal Muscular Atrophy, Typhoid Fever, Yellow Fever, Lobar Pneumonia, Dengue, Tuberculosis, Diabetes Mellitus, Gout Arthritis Deformans, Autumnal Catarrh, the Diseases of the Circulatory System, more particularly Hypertrophy, Dilatation of the Heart, Arteriosclerosis, Thoracic Aneurism, Pancreatic Hemorrhage, Jaundice, Acute Peritonitis, Acute Yellow Atrophy, Hematoma of the Dura Mater and Sclerosis of the Brain.

This work is particularly recommended to the advanced student, who will find it one of the best works in our language on the practice of Medicine. STORCK.

A Reference Handbook of the Medical Sciences by various writers. New edition. Edited by ALBERT H. BUCK, M. D. Volume I. William Wood & Co., New York. 1900.

In a notice of this volume and work sometime since, attention was called to the comprehensive scope of the projected work. The new edition is intended to cover the whole domain of medical and surgical research and to bring all information obtainable as near as possible to current knowledge.

In the published list of contributors, almost every field of medicine is directed by some one more or less distinguished in his line.

Volume I is made up of some 800 pages of matter arranged in alphabetic order from A to Bla., suggesting the scheme of the following volumes. The text is arranged in several types, making the encyclopedic material easy of access for reference. The illustrations are plentiful, being chromo-lithographs, half tone and wood engravings. From the examination of selected articles, the editor deserves to be congratulated upon the care in detail evidenced in the preparation. It is impossible to review the articles themselves, as their number precludes such a task. An idea of the extent of other articles may be gathered from the note that ten pages of small print of the quarto volume are devoted to acne—representing 40 pages of ordinary print. If succeeding volumes are as well edited and as complete as the first the publishers should have a deserved recognition in the sale of the book. DYER.

Clinical Examination of Urine and Urinary Diagnosis, by J. BERGEN OGDEN, M. D., W. B. Saunders & Co., Philadelphia and London, 1900.

We have never read a more clear and applicable text than the one before us. The subject matter is arranged for either study or reference, and the work is complete in every particular. Modern methods in technic are presented, and when laboratory principles are to be set forth, they are given with precise detail.

By far the most valuable part of the book to the practitioner is that devoted to urinary diagnosis. Here one disease after another is described from the urinary standpoint, and the analytic diagnosis is deduced. The text, type and illustrations are everything to be desired. DYER.

Progressive Medicine, Volume IV, December, Lea Bros. & Co., 1900.

This quarterly is always full of instructive articles and the present volume has several of interest. Among these are succinct reviews of the recent work in diseases of the stomach; on infections; surgical injuries; and a concluding chapter is devoted to new remedies. DYER.

PUBLICATIONS RECEIVED.

A System of Practical Therapeutics, edited by Hobart Emory Hare, M. D., Vol. II.—Lea Bros. & Co., Philadelphia and New York, 1901.

Infant-Feeding in Its Relation to Health and Disease, by Louis Fischer, M. D.—F. A. Davis Company, Philadelphia and Chicago, 1901.

A Treatise on Appendicitis, by George Ryerson Fowler, M. D. —J. B. Lippincott Company, Philadelphia and London, 1900.

A Text-Book of Diseases of the Nose and Throat, by D. Braden Kyle, M. D.—W. B. Saunders & Co., Philadelphia, 1900.

The Treatment of Fractures, by Charles Locke Scudder, M. D. —W. B. Saunders & Co., Philadelphia and London, 1901.

Hypnotism, by L. W. De Laurence.—The Henneberry Company, Chicago.

Manual of Venereal Diseases, by F. R. Sturgis, M. D.—P. Blakiston's Son & Co., Philadelphia, 1901.

Retinoscopy, by James Thorington, M. D.—P. Blakiston's Son & Co., Philadelphia, 1901.

Report of the Confederate Home, 1900.—Von Boeckmann, Schutze & Co., Austin.

Manual of Diseases of Children, by John Madison Taylor, M. D., and William H. Wells, M. D.—P. Blakiston's Son & Co., Philadelphia, 1901.

Pulmonary Consumption, Pneumonia and Their Allies, by Thomas J. Mays, M. D.—E. B. Treat & Co., New York, 1901.

Progressive Medicine, edited by Hobart Amory Hare, M. D., and H. R. M. Landis, M. D., Vol. I.—Lea Bros. & Co., Philadelphia and New York, 1901.

Tuberculosis as a Disease of the Masses, and How to Combat It, by S. A. Knopf, M. D.—M. Firestack, New York, 1901.

A Text-Book of Ophthalmology, by John W. Wright, M. D.— P. Blakiston's Son & Co., Philadelphia, 1901.

A Manual of Practical Hygiene, by Charles Harrington, M. D. —Lea Bros. & Co., Philadelphia and New York, 1901.

Reprints.

The Throat and Nose in Scarlet Fever, by W. Cheatham, M. D.

Treatment of Prostatic Hypertrophy, by Parker Syms, M. D.

Some Remarks on the Present Status of the Physician in the United States, by Emil Amberg, M. D.

Case of Gastric Carcinoma, by John Murray, M. D.

Two Hundred and Thirty-Seven Consecutive Abdominal Sections, by Chas. Gilbert Davis, M. D.

A Scientific Basis of Medicine—Life and Its Association With Matter, by E. C. Hebbard, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR FEBRUARY, 1901.

CAUSE.	*White.....*	*Colored...*	*Total .....*
Fever, Malarial			
" Intermittent	5	1	6
" Yellow			
" Typhoid or Enteric	7	2	9
" Puerperal			
Bronchitis	6	3	9
Diphtheria and Croup	2	2	4
Influenza	25	6	31
Measles			
Whooping Cough	1		1
Pneumonia	31	25	56
Cancer	9	4	13
Consumption	45	36	81
Diarrhea (Enteritis)	6	4	10
Dysentery	1	1	2
Gastro-Enteritis			
Hepatic Cirrhosis	3	2	5
Other Diseases of the Liver	3		3
Peritonitis		1	1
Debility, General			
" Senile	16	7	23
" Infantile			
Bright's Disease (Nephritis)	27	13	40
Uremia			
Heart, Diseases of	26	22	48
Apoplexy and Congestion of Brain	16	5	21
Meningitis	5	2	7
Tetanus	4	2	6
Injuries	7	15	22
Suicide	2		2
All Other Causes	76	48	124
TOTAL	323	201	524

Still-born Children—White, 19; colored, 9; total, 28.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 18.45; colored, 26.80; total, 20.96.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure 30.09
Mean temperature ..... 53.
Total precipitation, inches 5.78
Prevailing direction of wind, north.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. MAY, 1901. No. 11.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

DISINFECTION FROM A PURELY PRACTICAL POINT OF VIEW. ITS EFFICIENCY A PROBLEM FOR SOLUTION.*

BY JOHN J. ARCHINARD, M. D., Professor of Clinical Microscopy and Bacteriology, New Orleans Polyclinic; Chairman Section on Bacteriology, Louisiana State Medical Society, New Orleans.

The object of this paper is to bring before this Society the true status of the agents now in vogue classed as disinfectants, and to report upon a series of experiments made by me with sulphur dioxide, liquid air and formaldehyde to test the value of these agents as disinfectants and the practicability of applying same to house disinfection.

The use of disinfecting agents and perfumes date as far back as history of the remotest times. Proofs of same are found in Homer's Odyssey, where he narrates that Ulysses had sulphur burnt to purify his palace after he had ordered the massacre of the pretender to his throne and his unfaithful slaves. The vapor of sulphur was in fact the principal and exclusive agent used in Grecian and Roman antiquity as a disinfectant. The great epidemics of the Middle Ages, pest, leprosy, etc., led to practices of disinfection and quarantine which continued to the

*Read before the Louisiana State Medical Society, April, 1901.

end of the eighteenth century without humanity and hygiene ever reaping much profit.

Prejudices the most gross, empiricism the most blind, alone controlled the choice and the invention of agents reputed to be disinfectants.

In this age of progress of science and with our knowledge of bacteriology, the medical profession can not continue to accept as truths the inefficient disinfectants which our forefathers, with their limited knowledge of the cause of infectious and contagious diseases, handed down to us.

The object of disinfection is to prevent the spread of infectious diseases by destroying the specific infectious material which gives rise to them. There can be no partial disinfection; it is either complete or a farce. The following series of experiments were made to test the value of sulphur dioxide as a disinfectant:

EXPERIMENT I.—Room capacity, 1500 cubic feet; total amount of sulphur burnt, 15 pounds; time of exposure, 12 hours; percentage of gas determined by volumeter, 6 per cent. for four hours, then 4 per cent. for the two hours,and 2 per cent. for the balance of time. Room was sealed with newspapers, according to regulations of the Board of Health. Gauze strips infected with bouillon cultures of bacillus typhosus, diphtheria, coli communis were suspended at the height of 2, 4, 6, 8, 10 and 12 feet about the room and exposed to the disinfectant for the time mentioned and then taken out and planted in steril bouillon, incubated forty-eight hours and plated on agar. Result, *none of the bacteria were destroyed.*

EXPERIMENT II.—Same Room. Liquid SO_2 was used. Time of exposure, 5 hours; percentage of gas, 10 per cent. for two two hours, then 6 to 3 per cent. for remainder of time. Strips infected with same bacteria were suspended 2, 4, 6, 8, 10, 12 feet high about room. Bacteria were destroyed at height of 2 and 4 feet, but not in other places. Infected strips were also wrapped in thin layers of absorbent cotton and placed at same distance above named. Result, *no bacteria destroyed.*

Not feeling very much encouraged by the results we had obtained we decided to continue our experiments in order to ascertain the exact percentage of So_2 required and the time exposure necessary to destroy these bacteria.

After several experiments we concluded that in order to destroy the bacillus typhosus, diphtheria and coli communis that it required six hours exposure with 10 per cent. SO_2. These results were obtained in our laboratory under the best conditions in a hermetically sealed glass case.

By courtesy and in conjunction with Prof. A. L. Metz, I was enabled to carry on a few experiments to test the value of liquid air as a disinfectant.

Tubes of bouillon and agar cultures of the bacillus of diphtheria, bacillus typhosus, coli communis, anthrax and anthrax spores, also some cultures of the staphylococci were immersed without removing the cotton plug and allowed to remain in liquid air for two minutes.

The bouillon cultures remained frozen for 5 hours after their removal from the liquid air. The cultures were then incubated and after 48 hours, transplanted on steril medium. Result, *none of the bacteria were destroyed.* Liquid air is therefore not a disinfectant.

The latest and one of the best disinfectants known at present, is formaldehyde. Aronson says that for the disinfection of living rooms, there is no method that can compare in the remotest degree as regards certainty and simplicity, with that by means of formaldehyde gas. Formaldehyde gas is very penetrating, easily diffusing itself, and has strong bactericidal powers, and no doubt a very good disinfectant, but it is very necessary to have an apparratus discharging a sufficient volume of gas with sufficient rapidity to do the work. Prof. Robinson, of Bowdoin College, reports that the gas penetrated mattresses and killed the cultures wrapped up in them.

The following experiments were made to test the value of the Kuhn Formaldehyde Generator:

The room selected was of 1872 cubic feet dimension. Three pints of wood alcohol were consumed in the generator. The time of exposure was six hours. The material used for testing consisted of strips of filter paper dipped in virulent cultures of bacillus typhosu, bacillus of diphtheria and bacillus coli communis and allowed to dry. These strips were wrapped up in two, four and six layers, respectively, of an ordinary woolen blanket. The edges of the blankets were sealed together by means of parafin so as to prevent the formaldehye fumes from

reaching the contaminated strips except after passing through the different layers of blanket. The wrapped up strips were placed in the following places in the room: some on the floor, some on chairs, some on the mantel-piece, some in the corners of the room and some hung up on thread, nine feet high.

Following are the results:

FLOOR.—Strips of bacillus typhosus, bacillus diphtheria and bacillus coli communis, wrapped in two and four layers of blanket, *no growth.* Strips of same bacteria in six layers of blanket, *growth.*

CHAIRS.—Strips of bacillus typhosus, bacillus of diphtheria and bacillus coli communis in two and four layers of blanket laid on chairs in different parts of the room, showed uniformly no growth. Strips of same bacteria in six layers of blanket, *growth.*

MANTEL-PIECE.—Strips of same three bacteria above mentioned, wrapped in two and four layers of blanket and placed on the mantel-piece, *showed no growth.* Strips wrapped in six layers of blanket *showed growth.*

CORNERS OF THE ROOM.—Strips of same three bacteria as above, wrapped up in two and four layers of blanket and placed in the corners of the room *showed no growth.* Those wrapped up in six layers *showed growth.* Strips of the same bacteria hung nine feet high in room and wrapped in two and four layers of blanket *showed no growth.* Those wrapped in six layers showed growth.

In these experiments we proceeded as usual. After the contaminated strips had been fully exposed to the disinfectant they were taken out and planted in steril bouillon, incubated for 48 hours and plated on agar.

In addition to the above, experiments were made with sealed envelopes containing strips of filter paper which had been dipped in bouillon cultures of the bacillus typhosus, bacillus of diphtheria and bacillus coli communis, with the following results:

1. Envelope placed under generator, *no growth.*
2. Envelope attached to almanac on wall about six feet from floor, *no growth.*
3. Envelope placed under oil-cloth covering dining-table, *no growth.*

4. Envelope placed on sofa, six feet from generator, *no growth.*

5. Envelope placed on hanging lamp in centre of room, six feet from floor, *no growth.*

6. Envelope placed on back of picture frame hanging on wall, six feet from floor, *no growth.*

7. Envelope placed on a desk in a corner of room about eight feet from generator, *no growth.*

8. Envelope on table in opposite corner of room, *no growth.*

9. Envelope placed under a rug near the door of the room, *no growth.*

10. Envelopes placed in the four corners of the room, *no growth.*

The words "growth" signify that the bacteria were not destroyed and the words "no growth" mean death, same as a result of exposure to the disinfectant.

Besides methods of gaseous disinfection, the physician could contribute very much to prevent the spread of infection if he would direct his attention to the dejecta of patients, which are dangerous to the community.

In cases of diphtheria, for instance, the vomit, expectoration and nasal discharges are most important; they should be received in old rags or paper napkins, and should be burned.

The excreta from typhoid patients and all alvine matter, possibly the source of infection or contagion, should be mixed with a 5 per cent. solution of chlorinated lime (containing 25 per cent. of chlorin) and allowed to stand for one hour in vessels before being emptied.

The bedclothes, towels, napkins, handkerchiefs, etc., should be allowed to soak for several hours in a 1 to 1000 solution of bichloride of mercury before being sent to the laundry.

I must admit that sterilization by steam is the most efficient method of disinfection for bed clothing, towels, underclothes, etc., but this can only be practised in hospitals. It would be very expensive to construct autoclaves, and they could not be put to practical use in house disinfection. Furthermore, certain fabrics are injured by this method.

Dr. P. E. Archinard, bacteriologist of the Louisiana State Board of Health, in a series of practical experiments made by him to determine the value of formalin sprinkling as

a disinfectant for wearing apparel contained in trunks and valises, reports that woolen clothing and other wearing material which had been infected with different pathogenic bacteria were sprinkled with a 20 per cent. solution of formalin and closed in trunks and valises, and allowed to remain in same twenty-four hours: at the end of this time all bacteria were destroyed. None of the fabrics were injured or damaged by this process of disinfection.

In conclusion, gentlemen, I wish to state that a great many members of our profession are responsible for the spread of infection, either on account of their ignorance of the subject of disinfection or the insignificance they attach to its importance. To illustrate this, I will cite to you an instance. Some few years ago I met a friend, who was carrying two half-pound cakes of sulphur and a five-pound package of ordinary slaked lime. I asked him what he intended to do with these articles. He confided to me that his wife had just gotten over a terrible attack of typhoid fever, and during her convalescence his baby had contracted diphtheria, but that his physician had not reported the case to the Board of Health, on a promise to the doctor that he would disinfect his premises. Acting under instructions of his physician, he proceeded to strip his room and lime his water-closet. I wish to inform you that slaked lime is not a disinfectant, although the Council of the city of New Orleans, several years ago, acting according to their all-wise conception of disinfection, regardless of and seeking no advice from the Board of Health, *declared lime to be a disinfectant* and appropriated a fabulous sum of money to have this agent scattered around the excavations that were then in progress and along the gutters of certain districts.

The practice of such customs can no longer continue; they are comparable to the old faith in the virtue of camphor tied in a little bag and carried on one's person as a preventive of yellow fever and the garlic string around a child's neck as a preventive of convulsions.

From the foregoing remarks we are justified in drawing the following conclusions:

I. Sulphur dioxide being a disinfectant of low efficiency and worse still a destroyer of dyes, whilst utterly impracticable for thorough application, should be discarded at once.

II. Formaldelyde on the contrary is an agent of a great penetration and high disinfectant efficiency though practically harmless to colors and fabrics. Apparatuses are now being made for disinfecting rooms and contents by means of simple, cheap, harmless and easily managed methods of rapidly generating this gas. Therefore the immediate adoption of formaldehyde is much to be desired.

III. Bichloride of mercury recommends itself as a handy and efficient means of treating washable fabrics.

IV. Sprinkling with 20 per cent. solution of formalin and keeping in closed containers for 24 hours enables us to dispose of woolen and other wearing apparels not amenable to treatment by method III.

V. Chlorinated lime is our best method for disinfection of excreta, privy vaults, yards, drains, etc.

VI. Incineration is the best method of disposing of substances of no intrinsic value, such as rags containing dejecta, etc.

DERMOID CYST OF THE SCALP, WITH A REPORT OF A CASE.*

BY SIDNEY P. DELAUP, B. Sc., M. D., VISITING SURGEON TO CHARITY HOSPITAL, NEW ORLEANS.

DESCRIPTION OF CASE.—A mulatto, aged 21 years, a native of Louisiana, was admitted to the Charity Hospital in August, 1900. The little of his family history as he could give was entirely negative. He gave no history of any previous acute illness, syphilis or tuberculosis. He had never suffered any injury. From childhood he remembered having noticed a swelling on the vertex of his head. The swelling was not tender to the touch and increased in size as he developed. Aside from the presence of the tumor he considered himself in perfect health, being free from all febrile disturbance or other symptoms. The patient is tolerably well nourished, and a physical examination of the internal organs fails to reveal the presence of any organic disease. On the vertex of the scalp there is a tumor, the size of an orange, with the skin freely movable over it. The mass is evidently adherent to the underlying tissues; it is neither ten-

*Read before the Louisiana State Medical Society, April, 1901.

der nor sensitive, and gives a distinct sense of fluctuation. Aspiration by means of the exploring needle reveals the presence of thick, yellowish fluid of a honey-like consistence. Upon the supposition that it was a sebaceous cyst, its removal was advised and undertaken.

Under chloroform anesthesia an elliptic incision was made and the cyst exposed. It was firmly attached to the underlying periosteum, but no connection with the brain was discovered, though the bone presented a slight depression. On incising the cyst there welled up a thick yellowish fluid, some gritty matter and strands of hair. The wound healed per primam and the patient was discharged in a week.

EXPLANATION OF CONDITION.—Dermoid cysts of the scalp are of such rare occurrence that a glance at the literature of the subject may not be amiss.

From the earliest periods of the history of medicine to the present time congenital malformations have attracted the attention of medical writers, as well as excited the wonder and superstitious awe of the literate and illiterate laity. The works of ancient medical authors abound in frequent allusions to the subject, and in their attempt to furnish an explanation of the cause of such malformations they never went beyond the popular belief that these were punishments inflicted by the Almighty upon those who had been guilty of moral errors.

It was not until the end of the eighteenth century after Albrecht von Haller, the immortal physiologist, had laid the foundation stone of teratology in his celebrated work, "*De Monstris*," that the subject was considered in a scientific light, and that his deductions gave to the subject the character of a distinct branch of science. A few years later appeared Bichat, the creator of science of histology, who threw additional light on the complex structures of the body and reduced them to their elementary tissues, and demonstrated the essence of organic forms and the laws by which these forms are invariably directed. From his time the science of teratology became identified wtth embryogenesis and embryology. Although from that time on plausible hypotheses, and in some instances scientific theories have been advanced for the elucidation of the subject, there still remains a degree of obscurity as to the essential cause of the several known vices of conformation and anomalies of organization, yet

such has been the progress made within the past few years in teratology, that we are justified in stating the fact that we are gradually approaching to a clearer understanding of the genesis of all the varieties of malformations. Many theories have been proposed to explain these complex tumors, most of which deal not only with one variety, but frequently with a special localization of one variety. Nearly all are based on a congenital origin of these tumors and look to an anomaly of development for a reasonable explanation of their formation. A dermoid tumor is one which contains mucous membrane or skin. It is generally cystic and contains skin more often than mucous membrane, the skin being furnished with its various appendages. Although generally cystic, it is not unlikely that it originates as a solid growth, and subsequently becomes cystic by the retention of sebaceous matter, the secretion of sweat glands, and the accumulatian of exfoliated epithelium.

Dermoid tumors are benign in nature and difficult to diagnose. The diagnosis is not always possible before removal, and sometimes difficult afterwards, especially if hair, teeth, bone and other easily recognized characteristics are absent. In doubtful cases the condition is generally made plain by a microscopic examination ot the cyst wall. The size of dermoid cysts is very variable, some are small, not larger than a pea, others attain the size of an adult head. As to sex, observations show that both sexes are equally affected.

The most important characteristic of these tumors is their constant seat of election on the anterior fontanelle, above and in the middle of the forehad, near the sagittal suture. Frequently a direct communication with the cranial cavity is found, and the base of the tumor is found adherent to the dura mater.

The growth of these tumors is similar to that of all congenital tumors. The cyst forms a spherical or ovoid tumor, which is free on all sides except that which is attached to the cranial periosteum. After the tenth month, that is, after the closure of the anterior fontanelle, pulsation is not possible in the cyst, the tumor is then isolated from the dura mater.

Cerebral phenomena are never observed with these tumors, and local pain is noticed only after inflammatory complications.

Up to 1890, according to Cohen, there were altogether only 21 cases of dermoid cysts of the large fontanelles on record.

Only one remark as to the operation, and that is to exercise care to remove the entire tumor, not leaving a portion of the cyst wall for fear of a recurrence.

The origin of dermoid cysts is as obscure and uncertain as that of teratomata in general. It was Baillie, about the beginning of the nineteenth century, who divested it of the mystery and superstition in which it had been so many years enveloped. He refuted the old ideas by the discovery of an ovarian dermoid containing skin, bone and hair in a little girl, a virgin, twelve years of age. From the study of this case he was led to conclude that the genital organs of the human female were able in themselves, without fertilizaton, to generate and develop an embryo.

Later, Tumati wrote upon dermoids and regarded their formations as analogous to the double monster. Still later, Meckel proposed a theory which was accepted as being probably the most rational and scientific explanation that had thus far been entertained on the subject. He maintained that most malformations represent certain stages of the development of the embryo and its organs, at which stages formation has stopped short, or from which ulterior development has ceased to follow the normal type.

In 1854, Remak changed the views concering these tumors by showing that they were congenital and occurred by preference at positions in which fetal clefts, fissures, or sinuses previously existed. "Continued observations upon the tumors has disclosed the fact" Says Joseph McFarland, *Medical News*, 1896, "that this is in great part true. We find them occurring in the great median fissures of the body, both anteriorly and posteriorly in the mandibular fissure, orbital and naso-orbital fissures, bronchial clefts, in connection with the sutures of the brain case and naso-pharynx. The fact, however, that they occur with great frequency in the ovary, occasionally in the testicles, and frequently in the abdominal and thoracic organs is opposed to the theory of Remak." Every one knows that the ovary is the most frequent seat of occurrence.

Cleft formations, or such abnormalities as result from nonclosure of those parts of the body which are opened or separated in the embryo in the early stage of the normal development, but which at a later period should become united, furnish a scientific explanation of many forms of fetal anomaly.

Wilms (*Deutsch Arch. f. Klin. Med.*, 1895, *Bd.* L.V.) doubts the congenital nature of the ovarian tumor, and classifies many of the dermoid cysts of the ovary and testicles, representing all those of the germinal layers—mesoblast, epiblast and hypoblast—with the rudimentary parasites originating from a single sexual cell, and not as a result of the inclusion of a rudimentary twin.

If the tumors are not congenital, they must, of course, be developed in after life, and we must look in the tissues in which they occur for the cells from which they can originate. Wilms sees in the ovum itself a cell capable, when fertilized, of producing tissues of all kinds.

I agree with McFarland that it is very difficult to understand just how these embryonal cells could be included in the ovarian tissue, and much more difficult to understand how they could remain latent for a period of years.

The theory of the development of an ovum without impregnation has some supporters. It attributes to the germinal epithelium of the ovary the power of originating without impregnation various tissues, such as skin, nerves, etc. If that is so, it can be applicable to ovarian cysts also.

Cohnheim's theory of embryonal remnants, capable of producing different kinds of growths, depending upon the type of the cell, is reasonable, but it is strange why so many of these growths occur in the ovary.

The theory which has the greatest support by the greatest number of observers is that of fetal inclusion; that is, the inclusion within the body of a developed twin. This, too, is subject to the criticism applied to Cohnheim's theory, but it seems more plausible than any of the others. There is a semblance of truth in it if one is content to apply it to cases where unmistakable segments of limbs have been found; it is inapplicable to most dermoid cysts, as it does not explain the existence of such a tumor in each ovary, or the large number of teeth occasionally found in them. Mandlebaum advocates this theory and believes that in order to explain the multiplicity of tissues found in some dermoid cysts we must consider them to be formed by the process of bigerminal implantation, one of the twins remaining as a rudimentary undeveloped embryo.

In 1852 Verneuil, struck by the frequence of dermoid cysts

about the orbit and neck, that is, about the region where bronchial clefts are found in the fetus, expressed the opinion that in an abnormal process of occlusion of these clefts, a pinching of the skin could take place and as a sequence a locking of the little cutaneous sac. Quenu, while admitting with Verneuil that there exists a close relation of cause and effect between the dermoid cysts of the neck and head and the development of the bronchial apparatus, does not believe that is always necessary to invoke the pinching and locking, and advances instead the the idea of a process of epithelial involution. Lannelongue explains the pathogenesis of these cysts by calling attention to the theory of the locking of an ectodermic islet forgotten in the vascular tissue. As development proceeds in the embryo, the lips of the groove gradually come together and eventually fuse, transforming the groove into the medullary canal. The cavity of the canal becomes the central canal of the spinal cord and the ventricles of the brain, while its walls become converted into the various parts of the central nervous system. A group of cells belonging to the epithelial lining of the groove, that is, the ectoderm remain locked within the middle fold in the line of closure. These cells developing form the dermoid tumor, in the same manner as the islet remaining abnormally in the course of an embryonic fissure of the face, produce the bronchial cyst. To this origin belong not only the cyst of the bregma, as in our case, but also those of the glabella and inion, and even the intracranial cysts. All these cysts are situated on the median line, a fact which is in keeping with their pathogeny.

Lannelongue also endeavored to explain why dermoid cysts of the middle of the skull are found by preference at certain points on the bregma, inion and glabella, and why the intra cranial dermoid cysts are most frequently found near the torcular Herophili, a point opposite the inion. This explanation is that the three regions just given correspond to the points of union of the bones of the skull along the median line, and in the process of ossification of the bones, the locked islets are pressed out or pushed toward the fontanelle spaces.

Finally, it must be admitted that the pathogenesis of dermoid cysts is very obscure.

LUNG INFARCTION AND PNEUMONIA IN CARDIOPATHIES.—A CASE WITH POST-MORTEM EXAMINATION.*

By E. M. DUPAQUIER, M. D., (Paris), Professor on Clinical Therapeutics, in the New Orleans Polyclinic; Visiting Physician to the Charity Hospital, New Orleans.

Again, quite recently I have had the opportunity of observing the occurrence of hemoptysis in two cardiac cases and I thought it was a proper occasion for recalling before the Society, as practical and useful, firstly, a few facts regarding hemoptysis, facts that are often overlooked; secondly, a few remarks on the rational treatment of hemoptysis, including medicinal measures of recent date.

Occurrence of Hemoptysis in two Cardiac Cases.—A white man, age 55 years, came to my consultation room at the Polyclinic in November, 1900. He gave a clear history of rheumatism and alcoholism; it was an evident case of arteriosclerosis. He had a constant and long murmur, diastolic, taking the place of the second sound at the aortic focus, with a water-hammer or Corregan pulse. On Sunday, January 27, 1901, in the afternoon he was admitted into the Charity Hospital, and I found him in my ward when I called the next morning. He had a sudden attack of dyspnea with rise of temperature and hemoptysis. The diagnosis of pneumonia had been made. A few days later the patient was up, feeling comfortable, as he did before his admission to the hospital. March 5, 1901, he died. A comparatively quick death from cardiac dilatation. March 6, autopsy was held revealing chiefly, first, an advanced chronic aortitis; a sclerous sacculated aorta, enlarged as a whole from the aortic orifice inclusively, thus accounting for the murmur heard during life; secondly, two small cavities in the right superior lobe of the lung, due to sloughing of pulmonary infarcts which had caused the hemoptysis noted January 27, 1901.

I will briefly mention the chief features of the other cardiac case I have alluded to. He is a white adult, about 40 years, strong and robust in appearance. He is living. He is still in the hospital up and about. He was brought in by the ambulance in February with hemoptysis, dyspnea, rise of temperature. The diagnosis of pneumonia had been made. When asked by

* Read before the Orleans Parish Medical Society, March 23, 1901.

my chief of clinic, Dr. Chavigny, to examine the case, as he felt some doubt about the correctness of the diagnosis, I called his attention after examination to the cardiac arythmia existing, and I also questioned the diagnosis of pneumonia.

Summing up, here are two cardiac cases, the first, a typical aortic case, and the second a clinical myocardial case, presenting hemoptysis, both diagnosed pneumonia cases. In the aortic case, autopsy revealed that the hemoptysis had been due to lung infarction, which is usually the case.

Recalling a Few Facts.—We often overlook a number of facts in connection with hemoptysis. First, hemoptysis is not related only to pulmonary tuberculosis or pneumonia, but there are quite a number of diverse causes of hemoptysis. Second, in cardiac cases, though it is true pulmonary tuberculosis and pneumonia are of frequent occurrrence, *hemoptysis is most frequently the result of infarcts.*

Byrom Bramwell, of Edinburgh, writes in his remarkable treatise, "Diseases of the Heart and of the Thoracic Aorta," that in his early experience he mistook hemoptysis, due to mitral stenosis, for an incipient tuberculosis of the lung. Many others could confess a similar error. It is a fact that not only in initial affections, but also in aortic cases pulmonary tuberculosis is very common; and, by the way, a young student present at the autopsy, unaware, probably not knowing of the scientific and long debate on the question of pulmonary tuberculosis and chronic aortitis, summarily called the infarcts Dr. Pothier and myself were examining, "phthisic cavities," showing the elementary impression that hemoptysis in life and a cavity at autopsy mean phthisis. It is not so, however. In the aortic case reported here, as in many other cardiac cases, the history showed no tuberculosis. The fact is that hemoptysis in cardiac cases is always due to thrombus, embolus or infarcts of the lung in aortic as often as in any other cardiac case. Again, referring to the case reported here in chronic aortitis, and in arteriosclerosis, hemoptysis is most frequent, because the bronchial arteries are themselves diseased, and the usual bronchiectasis of arteriosclerosis is so typical that it can be differentiated from phthisic cavities at the post-mortem.

Summing up, the apparently clinical pneumonia in the aortic case reported was not a pneumonia but a pulmonary infarct due

to the embolic plugging of a pulmonary vessel probably by way of the bronchial arteries which you know anastomose with the pulmonary capillaries.

A few more facts. I told you how the aortic case reported, though he had the extended lesions revealed by autopsy, presented comparatively little functional disturbances until sudden cardiac failure quickly carried him off. Huchard, the French authority on the heart and vessels, has well merited the praise and thanks of the profession for having insisted so much upon the long, silent, latent period of chronic aortitis when the patient is apparently comfortable and death comes quickly by, if not a sudden, at least a rapidly progressive cardiac dilatation. I told you how the myocardial case reported presenting hemoptysis and irregular rythm, indicating a marked arterial sclerosis of the heart, is looking apparently well and strong just now. I can not but recall here in the presence of these two cases the importance of arterial disease and insist upon the necessity for us of constantly bearing in mind the myocardial changes resulting from changes in the coronary arteries which are at the present day better understood. The patient is taken sick *by surprise* and death comes like a thunder bolt, before the physician can detect the real morbid condition and give effective help.

At some future time I will consider before the Society the question of arterial tension in reference to the latest mechanical methods of gauging blood pressure and of measuring the intensity of the heart tones, namely, tonometry, stethophonometry, which may prove to be valuable guides at the time vascular changes are not easily detected. I will briefly state to-night that we must educate ourselves in the digital method of estimating pulse tension. There lies an important factor, the consideration of which would prevent the subsequent evolution of arterial disease if we only have the co-operation of an intelligent patient. Let us, at the earliest possible moment, detect high arterial tension, for it is an early and prominent symptom of the common uric acid diathesis which is all important in clinical medicine, as it leads directly to arterial disease. In more than one instance in the history of confirmed arteriosclerosis I have noted, with the common palpitations after eating, the occurrence of hemoptysis, at an early date.

Treatment.—In cases of hemoptysis like these reported here, in cases of hemoptysis of cardiac origin—well, in fact, in cases of

hemoptysis occurring not only in tuberculosis, but in all other circumstances, what must we do? Abstain from madly rushing to the use of cardiac tonics and hemostatics, but stop to think!

Except in rupture of an aneurism of the aorta into the air passages, or of some pulmonary aneurism, in cavities of advanced phthisis, which cases are beyond our assistance, of course, hemoptysis is never fatal itself; it might be serious, protracted and call for drug treatment, but usually it does not. In cardiac cases it is often a relief to the engorged vessels; in fact, nature is doing what is rational to do in many cardiac cases, namely, wet cupping and bleeding. Of course, in many cases it is a signal of an alarming condition, broken compensation, weakening myocardium; but here, now, if such is the case, before giving digitalis, strychnin and caffein, first try rest in bed alone, absolute rest in bed; and I have found this to be amply sufficient in the majority of cases. Rest is a great therapeutic measure. If rest alone fails, I certainly do not object to the use of cardiac tonics. But I always use them, chiefly digitalis, with the greatest caution.

In teaching enlightened therapeutics to the Polyclinic class in clinical therapeutics, I exercise particular care in condemning the misuse and abuse of digitalis, chiefly, and the shocking careless administration of other powerful drugs, in general. Speaking to the point on this subject of hemoptysis, ergot is another drug of routine use in practice. As a hemostatic it is most uncertain, to say the least. Who can rise and say that he can rely on ergot as a hemostatic in hemoptysis? In fact, all our so-called hemostatics are practically useless in the treatment of *internal hemorrhage*. Their external or local vaso-constricting effect is doubtful when they are administered internally.

In this particular hemorrhage, hemoptysis, of all the drugs that I have tried I positively rely only on three, now, when drug treatment is necessary; namely, opium by the mouth or morphin hypodermatically, quinin in tubercular hemoptysis with fever. Next to these ipecac in nauseating dose has served me best. As for tannin as a hemostatic, it is useless except perhaps in some cases of gastro-intestinal hemorrhage. Turpentine, lime juice, calcium chloride, and all other conventional hemostatics given in text-books are of little practical value.

In a very recent case of hemoptysis of tubercular origin I have given the latest hemostatics a trial, I mean gelatin and

suprarenal gland. Good reports have been published upon the use of both drugs. In my case I had some rapid effects, but I can not say that mere coincidence did not interfere here as a factor. Now, gentlemen, while I am skeptic as to faith in our hemostatics, whether they are vaso-constrictors or coagulants, in cases of hemoptysis, I do not remain idle in such instances. My skepticism I keep within myself, and I do not, of course, discuss the matter with the patient, who is so anxious that something may done for him. I realize this at once and to quiet the patient I remain with him for awhile, encouraging him, giving directions for his comfort. "Now, lie still in bed," do I say, in a firm but gentle tone; "don't move, the spittoon will be brought to your mouth; don't pitch over it to look at your spitting; don't open your mouth to speak a word; speak with your eyes; take a sip of this warm sweetened water with gelatin or flaxseed to soothe your cough;" and I hold the cup myself to his mouth. "Nurse," I say, "open the windows and keep them open; wrap the patient's limbs from the toes up in absorbent cotton or blankets." Now I have said all that I wanted and I have done some good work. Should the cough persist in tubercular cases I order opium or morphin for the chief purpose of quieting the cough and therefore arresting the hemorrhage. I insist upon the use of warm drinks for the same purpose, instead of giving cracked ice. As for the ice bag, when I can, and I seldom can, locate the spot of the hemorrhage, I use it. Of course, I give my attention to the diet and relieve the bowels gently inside of the twenty-four hours. I need hardly insist upon the dangers of alcohol in bleeding cases; but it is necessary to do so, as alcohol is a drug which is still, more than digitalis and opium, *terribly misused.* I have seen, in consultation last summer, in a case of hemoptysis, not only alcohol and ergot ordered, but digitalis, and mind you, the case was a febrile one, the very case in which digitalis is *counter-indicated in hemoptysis cases.* I report the fact to show to this society of progressive men how some practitioners have a summary therapeutics—palpitation meaning digitalis, and bleeding ergot.

CHRONIC GASTRITIS WITH EROSIONS. A CLINICAL LECTURE.*

By OTTO LERCH, A. M., Ph. D., M. D. Professor on Clinical Diagnosis in the New Orleans Polyclinic, Etc., New Orleans.

This patient, a private patient who has consented to come here, is a baker 55 years of age, born in Germany and came to the United States in 1866. His father died at 74 years of age; his mother is still living and 78 years old. No nervous diseases and no consumption in the family. Five brothers and one sister are living and healthy.

When a child, he had measles and whooping-cough, and later in life, typhoid fever and influenza. He denies having had any of the venereal diseases and though he comes from a malarial district, he claims never to have had a chill in his life.

His habits are temperate. He never takes whisky and only occasionally a glass of beer. He uses tobacco but not to excess.

He tells us that seven years ago he threw up blood. He describes this characteristic and we hardly can be left in doubt that the blood came from the stomach. He claims to have been in perfect health before the attack and is unable to assign any cause for the same which took him without warning. At that time, not before and not after, he passed blood with his feces, he states that they looked black and tarry. From that time on his health commenced to fail; that is, not a steady loss but he was now losing and again gaining for about two years when he had another attack. This time the blood, estimated by him, amounted to not more than a tablespoonful. Another intermission of about two years followed and then another slight hemmorrhage, still less than the last one, on this, like on the two previous occasions, he noticed tarry stools. During the last year his health has commenced to fail more rapidly.

He complains now of a severe dull pain over the stomach region, especially at night.

He does not notice any pain after swallowing his food but states that he feels it more on an empty stomach and that the pain is frequently relieved by a glass of milk or ingestion of some other food. Eggs, meat and milk he is very fond of and digests them well; sweets and fruits increase his pain and cause

*Before the New Orleans Polyclinic Class, 1901.

him to vomit. Bread he digests fairly well; potatoes and other starchy vegetables he can not eat. He also complains of frequent and troublesome belching. His appetite is good. Bowels are constipated; feces of normal color. He sleeps but part of the night and, if we are to believe him, very often not at all.

If we now examine him we find him a man of medium size, fat and muscule tissue wasted, facies careworn and extremely nervous. The skin is dry and of a dirty color, with an icteric hue, especially noticeable in the face, conjunctivæ and mucous membranes of mouth. The skin of trunk and extremities show a healthier color. No edema, no exanthem and no pronounced cachexia, though the general appearance reminds us very much of one. A search for enlarged glands is negative. The chest organs are normal and so are the liver and spleen. No pain on palpation, no increased or diminished size of liver dullness can be detected, nor can the border be palpated. The general aspect of the abdomen is normal; no special tympanitis and no pain except over the stomach region. The pain is diffuse and increased on pressure. We find no pressure point. The epigastrium is not especially painful, and over the cardia, between twelfth and thirteenth dorsal vertebrae, an entire absence of pain.

To determine the size and location of the organ we select the method of inflation, and can readily make out the normal size and position of the organ.

On palpation we can detect a slight thickening over its left portion. Urine free from albumin, casts, sugar and bile; specific gravity 1020; reaction acid; large amount of phosphates present. Blood is that of an anemia; that is, the red cells are diminished in number; they are flabby and of a very pale color; no increase of white cells, absence of plasmodium malariæ.

Examination of stomach contents: In the morning only acid mucus can be expressed, and not much else, five hours after a meal. Ewald's test meal is partly digested; total absence of lactic acid and increased amount of hydrochloric acid.

The patient up to this time has been treated with anodynes and stomachics, and during the last year he has used lavage once, twice and sometimes three times during the day and at night.

To arrive at a positive diagnosis in this case is only possible by exclusion.

The patient has had three small hemorrhages within the last six years, all combined with tarry stools, and no doubt can be left that the blood at each time came from the stomach.

Is the hemorrhage due to a disease of the stomach or to some other cause will be the next question to be answered. I think we can exclude readily the few causes that can come in question. We have negative history of potatorium, of high living and of syphilis, and he has a healthy liver, as far as can be made out by physical examination. The healthy chest organs, the normal liver and spleen permit us to exclude an obstruction in the portal circulation or varicose veins as cause of the bleeding.

Another source of hematemesis is the esophagus, and as we have excluded varicose veins as a source, not being able to find a cause for venous stasis, of which liver cirrhosis is the most frequent one, carcinoma and ulcus esophagi remain.

The patient described the blood as of brown-red color and partly coagulated. The character of the blood coming from a lesion in the esophagus would be fresh. The tarry stools can not always serve for differentiation, as a part of the blood might pass through the stomach into the intestines. The passing of the stomach tube, however, in which he has become an expert through long and constant practice, could not be done without pain, and pain would be present immediately after swallowing food. The passing of the stomach tube without trouble excludes a stricture esophagi; nausea and vomiting after eating are never absent in ulcus esophagi. This consideration leaves us carcinoma ventriculi, ulcus, or erosions of the stomach as a source of the trouble.

Against a carcinoma speaks the following complex of symptoms: Absence of tumor, long standing of the disease, absence of coffee ground vomit, normal size and position of the organ, absence of enlarged glands and pronounced cachexia, absence of lactic acid and presence of hyperacidity, due to hydrochloric acid. I will further mention that people affected with a malignant disease of the stomach have always a disgust for meat; the reverse is true in our patient, who is fond of meat, the very food he enjoys.

If we now think of an ulcer as the cause of the hemorrhage, we hardly can admit its presence. The absence of typical pressure points, and the peculiar character of the pain in our

patient, who is relieved by ingestion of food, and who suffers, especially at night, when his stomach is entirely empty, so different from the characteristic pain in ulcers, which commences after eating, rising with digestion and disappearing gradually till it entirely ceases with an empty stomach, speak strongly against this view. A tumor at the pylorus, sometimes due to a chronic ulcer, can not be detected, the slight thickening felt over the left portion of the stomach is likely due to a perigastritis set up by the frequent introduction of the tube over so long a time. The hemorrhages observed during six years have been small, the last not amounting to more than a teaspoonful, certainly not usual in ulcers. These symptoms, I believe, are sufficient to exclude the diagnosis of this lesion—chronic gastritis with erosions upon a neuropathic basis will be our diagnosis.

The contents of the stomach contain mucus and an increased amount of hydrochloric acid. This with the occasional hemorrhages indicate that the mucous membrane of the stomach is inflamed, and that the symptoms are not due to a neurosis alone. Besides, you notice the marked wasting, the almost cachectic appearance of the patient and the slow and steady progress of the disease, with now and then an improvement interrupting the general course.

That the catarrh is based upon a neuropathic condition is shown by the appearance of the man, the characteristic expression of his face, the way he relates his troubles and the character of the pain, *especially severe on an empty stomach.*

Whether the catarrh has preceded the neurosis or this has been implanted upon the former, we can not now tell. No doubt any man may develop such a condition if he washes his stomach several times a day. He will finally have too much stomach on his brain.

TREATMENT—If our diagnosis is correct, we will have first of all *to withdraw the stomach tube* and improve his general condition.

Fresh air, that is, plenty of oxygen, it is the most needed therapeutic agent in this case.

The patient suffers from a severe anemia, loss of hemoglobin and great diminution of the number of red cells; in other words, the oxygen carrying capacity of the blood is enormously decreased and in consequence metabolism is carried on below par.

We will advise our patient to sleep with open windows and spend his days in the open air.

The next indication is to procure a much needed rest of mind and body.

The first we can do to some extent with a firm, and if necessary repeated assurance that his trouble is curable and that he will improve under our treatment. The bodily rest we will have to prescribe and will do so by directing the patient to rest after each meal in a half darkened room and go to bed at regular hours.

Of not less importance is the *diet.* He has found out for himself that the nitrogenous foods agree well with him and so we will permit him to eat anything he likes, gradually leading up to a mixed general diet as we correct his faulty digestion.

As the pain becomes severe when the stomach is empty we advise our patient to *sip* a glass of milk between meals and at night before going to bed.

Exercise—He has to take moderate exercise between meals according to our directions which of course we will have to vary as we go along with the treatment.

Finally we have to consider the treatment with drugs. Iron and arsenic are indicated to improve the condition of the blood. We will give him a tablespoonful of Gude's peptomangan combined with three drops of Fowler's solution of arsenic three times daily after eating. The digestion we will correct with a pancreatin preparation given with the meals; and hyperacidity we treat with burnt magnesia and a small amount of codein added. The magnesia acts as an antacid; at the same time it exerts a gentle influence on the bowels and the codein beneficially influences the secretion of gastric juice in this case. Not to interfere with the digestion of proteids we will direct him to take a small teaspoonful of the following preparation two hours after each meal:

℞ Magnesia Ustæ 15.0
Codein. phosphate 0.3
Sig. In water. Ft. pulv.

Sleep.—We will secure him sleep if needed with the bromides. To this treatment we may add some hydrotherapic measures. A cold ablution over chest in the morning, followed by vigorous friction as a general stimulant and a prolonged warm bath every other night as a quieting and soothing measure. We have to leave

the question whether at any time an ulcus existed undecided, and we have to remember that though the diagnosis of ulcus carcinomatosum, a very rare affection in itself, is based upon hyperacidity and tumor, at least one case without tumor cachexia present has been reported by Boas after autopsy had been made.

NOTE.—After the patient was treated for three weeks he was again introduced to the class. He was able to dispense with the bromides and magnesia preparations and in four weeks, very much improved, with a steady gain in weight, and his skin clearing up, was able to leave for his home in Texas.

Clinical Report.

TRAUMATISM OF EYE; DISCREPANCY BETWEEN CAUSE AND EFFECT.

BY DRS. BRUNS AND ROBIN, NEW ORLEANS.

The following case well illustrates that the mildness of a traumatism of the eye may be out of all proportion to its cause. Mr. G., aet 37 applied to our clinic for treatment on May 25, 1900. He stated that on the preceding morning, while blasting stumps with dynamite, a cartridge containing one pound of dynamite exploded accidentally while patient was standing about 18 inches from it. Recovering from the temporary stunning he complained of no injury except an irregular dilatation ofpupil and impaired vision of the right eye. Examination with the ophthalmoscope showed pupil dilated almost to maximum but irregularly, the lens diffusely cloudy so that no viewof fundus is possible.

At 3 o'clock P. M., of the same day he complained of pain in right eye coming on suddenly and persisting till next morning. On May 26, examination revealed anterior chamber full of blood and eye tender on pressure T+1. A two per cent. solution of boric acid and cocain ordered to be used every two hours. Hot applications frequently. May 27—Pain less severe. Same treatment continued. May 28—Eye looks decidedly better. Blood in anterior chamber nearly completely absorbed. Patient

free from pain. Ophthalmoscope reveals large and numerous vitreous opacities. Blood in anterior chamber completely absorbed. Pupil elliptic in shape with long axis vertical but dilated to maximum. R. E. V. $= \frac{7}{cc}$. Ordered ℥i of belladona and mercury ointment (ext. belladonna ℥; to ung. hydrarg. ℥); rubbed into forehead daily. June 7—R. E. V. $= \frac{6}{cc}$. No change in treatment. June 19—R. E. (atropin) V. $= \frac{20}{cc} - 3^s = \frac{20}{xl}$. July 5—R. E. injection has completely subsided; no pain, V. $- 3^s = \frac{20}{xl}$ fairly. Ophthalmoscope: large floating flakes in vitreous. Patient was discharged this day practically well with advice to continue the application of salve to forehead for several weeks.

It is pertinent to remark that the cocain instillations were made not only with a view to relieve the pain but also for its well known properties to reduce the intra-ocular tension which on the second day was markedly elevated. The belladonna and mercury salve exercised a mild and continuous effect on the pupil and accommodation and promoted the absorption of the blood and vitreous opacities which are evidently the result of hemorrhage into the vitreous.

New Instruments.

A NEEDLE FOR SILVER WIRE.

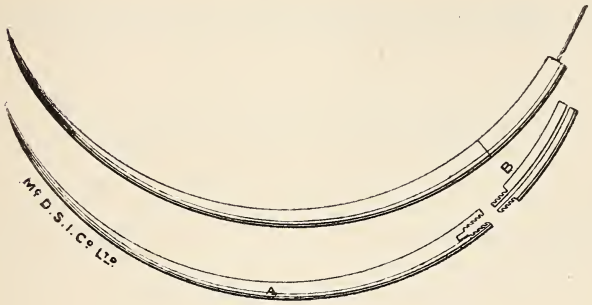
L. J. Y. GENELLA, M. D., B. L., NEW ORLEANS.

A silver wire looped over four strands of silk makes a great mass of unwieldly material.

The new needle proposed is easily sterilized, cheap, does not traumatize tissues and can be easily threaded placed in a sterilized test tube and carried in an obstetric bag as a readily prepared stitch for perineal work.

Its principal parts are:

The small end of the needle has a tunnel cut in it, through which the silver wire is passed, and the end compressed with forceps to make a shoulder on the end of the wire. After the boulder is made the end cap B is screwed into the needle.



The cut represents the needle made after the model of a curved surgical needle.

The needle can be made to ape any model.

McDermott & Co., of New Orleans, are the makers.

The Charity Hospital of Louisiana Alumni Association held its seventh annual meeting on April 22, 23, 24, 1901.

A series of Amphitheatre Clinics and Demonstrations had been arranged for the occasion and took place at the Charity Hospital as follows: Monday, April 22, at 9 A. M., by Dr. C. Chassaignac, and at 10:30 A. M., by Dr. F. W. Parham; Tuesday, April 23, at 9 A. M., by Dr. E. S. Lewis, and at 10:30 A. M., by Dr. P. E. Archinard; Wednesday, April 24, at 9 A. M., by Dr. J. B. Elliott, Sr., and at 10:30 A. M., by Dr. R. Matas.

On Wednesday evening the regular order was carried out. In addition to the routine business, Dr. J. D. Bloom read his address as president and was well received. The oration by Mr. E. B. Kruttschnitt was missed owing to the calling away of that gentleman. This caused intense regret and disappointment.

Dr. L. G. LeBeuf was unanimously elected president and Dr. J. J. Ayo, vice-president. Dr. Seeman was chosen secretary and Dr. Stafford, treasurer. In addition to the ex-officio members, Drs. Gordon King, Nelken and Gabert were selected as executive committee.

The banquet closed the pleasant reunion and was a pronounced success.

N. O. Medical and Surgical Journal.

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

THE STATE MEDICAL SOCIETY MEETING.

It may not be amiss at this time briefly to review the work of the Society at its recent meeting in New Orleans. Every year demonstrates more and more the importance of this body in the State and the last meeting has not proven any exception.

In the first place the attendance was excellent throughout and the interest evidenced was a warrant of appreciation of the program. Almost all of the technic discussions were liberal and the meeting was noteworthy for the fact that several questions of public concern were taken up.

Some quarantine methods, especially the sanitary needs of consumptives and the patent medicine habit were fully discussed. Resolutions developed recommending the isolation of the consumptive poor and it was brought out that the need was urgent in this community.

Among the features of the meeting was the exhibition of blood changes in the several infectious diseases and the importance of these in diagnosis of such affections as malaria, sepsis, syphilis, etc. A beautiful exhibition of slides was made by Dr. L. H. Warner, the pathologist to the N. Y. Skin and Cancer Hospital.

An elaborate story of the mosquito's life history and the morphology of the several parasites incident to the anopheles and culex were brought out by Prof. Geo. E. Beyer, eminently filling the Chair of Biology in our Tulane University.

Color photography from the standpoint of art, science and in its application to the teaching of chemistry, mineralogy and skin diseases was beautifully demonstrated by Prof. A. L. Metz, of the Tulane Medical Department.

The President, Prof. Parham, of the Polyclinic, made a strong argument for the sanity of the profession and the public in his address which was directed at the superstitions of all ages and the fetiches and fads which still cling to an otherwise intelligent and advanced people of the twentieth century.

The fields of special and general surgery, pathology, medicine and the specialties were fully represented upon the program which in its fulfilment and in its discussion was as creditable to our Society as it would have been to any like body in the country.

We are glad to see that the next meeting is to be in Shreveport, in June, 1902. The wisdom of having an occasional meeting elsewhere than in New Orleans must bear a natural fruit. In the first place, it will create new interest in these men living in North and Northeast and Northwest Louisiana. It will stimulate in each of the parishes in that section a desire to keep in line with medical progress as the Society shows the way. It will besides allow the large number of the members of the Society resident in New Orleans the opportunity of seeing how well our Shreveport brethren will arrange a meeting of our popular body. It is timely, too, now that our next president is to be a prominent member of the Shreveport profession, Dr. T. E. Schumpert.

In another year or two, our friends in Monroe, Baton Rouge, Lafayette, etc., will want and should have the chance to have a meeting with them. It must always be remembered, however, that New Orleans is the home of the Society and that at least each alternate meeting should be held in the metropolis.

With the renewed interest in the future of the Society, the members should take this as a reminder that the JOURNAL is the official organ of their body and that from now on the pages devoted to the Society ought to be full of items of interest to the members. We shall always be glad to notice any news items from any member and we are particularly anxious to have contributions to our reading pages from the members. With a realization that another year of successful gathering the Society must advance with long strides, we wish each of the participants a deserved congratulation.

PHYSICIANS' INCOMES.

Every now and then a suit for fees and the court procedures incident thereto direct the attention of the public to the pay doctors receive. Popular impression has grown into a belief that the occasional demands for exceptional fees are the reflex of the actual incomes of physicians. The natural social position of the medical man who behaves himself and the display which accompanies his own desire to appear *comme il faut* again create the idea that he is producing all of this from the earnings of his profession. While this is true, it means that it is a part of the medical man's investment of his income as one line of his business, and an investment which often consumes most of his income.

For the amount of actual labor, both in the expenditure of physical effort and measured by units of hours spent in occupation, the average medical man is more poorly paid than any other class of educated men. This proposition is not a new one, and it has been threshed over and over from different viewpoints.

The glamor of uncommon knowledge, the social prestige, the opportunity for original research, the humanitarian cause, the family tradition, the easy road to a diploma in an underclass college, are each and all among the reasons for the study of medicine. That profit fails of materialization is only too evident from the number of men who fall by the wayside after a time of effort; the race is too hard and too long. Some forty per cent. of graduated physicians either do not qualify or else in a few years drift into more profitable, not always more congenial, work.

It is not intended here to compare the ease with which any lawyer realizes more in one day than most doctors earn in over a year. Sometimes the fee is greater than the income of a dozen doctors for a year; nor do we wish to more than mention the income of ministers, usually assured whether they are sick or well; nor of chemists, engineers, etc. Dr. A. K. Steele, quoted in the *St. Louis Courier of Medicine*, in a paper before the Chicago Medical Society, gives a list of fees received by Chicago physicians, which bears out the foregoing: The average physician of Chicago has an income of $1500 to $3000. Office

specialists—eye, ear, nose and throat, average $2000 to $6000 per annum; consulting physicians, $5000 to $15,000; six leading physicians, $15,000 to $35,000; six leading surgeons, $20,000 to $60,000; six leading gynecologists, $10,000 to $20,000; six leading office specialists, $10,000 to $15,000; average surgeons, $3000 to $10,000. Chicago physicians with incomes of over $30,000 from practice can be counted on the fingers of one hand; probably not over twenty receive over $20,000.

The reasons for the larger income of the few and the smaller income of the many should be somehow obtainable and time should bring about some relief of so palpable a wrong to intellectual effort.

We may not have digested the question sufficiently to have an authoritative opinion, but the evils of the matter before us seem to justify a discussion. There are several evident and glaring reasons for the present status of the doctor's income which have evident remedy:

1st. The physician himself, underestimates the value of his services and thereby creates the lowered estimate of the patient himself. Except in occasional rural communities no endeavor has ever been made to regulate uniformity in charges for well defined services. The very existence of competition creates the false idea that practice is more lucrative when prices are a matter of comparison and that by charging less than another man one physician betters himself.

2d. The abuse of the doctor's knowledge and training by the multitude of the quasi-poor, who are unscrupulous in obtaining advice under false pretences, because the negligence and carelessness of the average physician seldom demand the legal protection and redress.

3d. The competition of free hospital and dispensary services, ostensibly organized for the poor, but really providing an effectual opportunity to the undeserving to obtain medical advice for what they are able and for which they should be made to pay. Oftentimes these institutions serve no other purpose than a political end, occupying in the community a false position as dispensers of charity.

4th. The vast number of irregular colleges, duly legalized, with unqualified faculties, without any standard of graduation, or-

ganized for pecuniary gain, which sent out into the field of medical practice a horde of men either ignorant of the needs of the profession or unscrupulous in their of lack knowledge. From the ranks of such are recruited the charlatans who infest every community, urban or provincial.

5th. There is a sad lack of legislative control of medical practice. In some States there is none, and in those States where laws do exist, every loophole for circumvention of the law is availed of. A wrongful competition is created, the sort of competition which in any other occupation, professional or commercial, falls and must fall, for its evident saturation with methods of dishonesty and deceit.

6th. Well bred medical men hesitate to take the stand for their own defense and rights, lest they may be misunderstood by some of their own kind. A conservatism in method is created which is based on false ethics and which bears only such fruit as disappointment, absence of appreciation, and even disparagement of a real ability.

Perhaps other reasons might be advanced, but these are pertinent, and they argue almost in corollary their own relief. This relief must rest upon these lines of effort:

1st. Better medical organization and a more complete fraternalization in the profession. The former because organization means power, and power means force, and righteous force must carry effect. The latter because only when men understand and justify each other can effort result in action for a common good. The several local and general associations for medical progress in this broad land are every day growing to these ends, but they should grow faster.

2d. When the rank and file of the profession take up the questions of self-protection and advancement and join with their leaders in demanding proper legislative enactments for qualified medical practice, the result is bound to eventuate. If Ohio can regulate food and drug products, Texas and California, Florida and Maine and all the States between can do the same if they want. Nostrums are imposed upon the people because their natural advisers and protectors in the profession are unwilling to fight the issue to a finish.

3d. The accepted code of ethics should be revised. The elements in it directed at compelling a medical man to remember

that to be a physician means to be a gentleman, should be left intact for the benefit of those who perchance may not have such qualifications to begin with; but the profession has advanced to-day to that point where it is no longer surrounded by a Chinese wall of mysteriousness and superstition. It is an axiomatic principle in political economy that the demand regulates the supply. To-day the public demands open methods of practice. In every field of art and science, excepting medicine alone, the world seeks and finds enlightenment. In the public schools, in the lay press, in the periodic magazines, in the congresses and expositions, fairs and conventions, local, state, national, international, every field of science or of art is elucidated in greater or less degree. The results of electricity in the laboratory, the chemist's discoveries of newer methods and results, the inventor of appliances, all being before the public in the most elaborate and far-reaching way, the evidence, procedure and ultimate results. Iconoclasm was the motto of the nineteenth century and elucidation must be that of the twentieth.

The charlatan profits by the conservatism of the medical man; the masses want education and because they do not get it, they accept the substitute, a well devised pretense. The public demands advice and explanation, and because it is given with an air of incomprehensibility about it, they take the substitute and suffer because they believe they profit by the imposition.

4. Finally, hospital and dispensary practice should be regulated by law carrying punitive measures for violation. The practice in these institutions should be done by men qualified and paid for their services; so that the indigent poor could be properly handled and benefited. Some day in the near future, the medical profession may demand that the State should duly and properly pay for services rendered to the public which is at all times the charge of the State.

The medical man is no longer a child of circumstance. The evolution of his broader education as instilled in the modern first grade medical college has made of him a citizen in fact, with all the privileges of such and it is only by his own neglect of his rights, that he will continue to suffer the hardships of the underpaid and under-classed.

Society Proceedings.

ORLEANS PARISH MEDICAL SOCIETY.

Meeting of March 23, 1901.

Dr. Dupaquier read a paper on "*Lung Infarction and Pneumonia in Cardiopathies; A Case with Post Mortem Examination.*" (See p. 651.)

Discussion—Dr. Storck: Had observed that a prolonged first sound was a forerunner of endocarditis. Had seen a few cases of infarction, aortic in character, in which, however, no post-mortems were held. In myocarditis pain is usually pronounced and pulse dicrotic. In all cases of arythmia Dr. Storck uses belladonna with whatever other treatment is indicated. This drug acts well in these cases.

Dr. Blum reported a case of hemoptysis from tuberculosis. Hemorrhage recurred on second day, and pulse was slow, with high tension. Morphin given hypodermically. From one to one and a half pints of blood had been lost. Aconite was given. Patient did well. Next day hemorrhage recurred. Gave aconite in small doses and morphin hypodermically. Hemorrhage again next day. Suprarenal extract in one grain doses was given. Dover's powder, 5 grains, was tried. Hemorrhage continued for two or three weeks. Gallic and tannic acids were tried. Practically no result. Meanwhile, rest, low diet and ice-bag had been ordered. Of all therapeutic agents used, only morphin was efficient.

Dr. Joachim inquired whether there was any perceptible difference between the hemoptysis of tuberculosis and that due to cardiac disease. Had himself had considerable clinical experience with internal hemostatics, all of which were of little use. But results were to be obtained by rest in bed, absolute rest. Most reliable medicine was opium, given in small doses and repeated until respirations were slowed. The lungs were thus given physiologic rest, as was also the case when heavy ice-bags were used. The value of an ice-bag lay in its weight, and its coldness mattered little.

Dr. Genella thought Dr. Blum's case could have been benefited by ligating three of the extremities at a time. Had seen this effectively used by ranchmen to control pulmonary hemorrhage.

Dr. Blum had seen this procedure recommended, and had ordered it for his patient, but it had not been carried out.

Dr. Barnett always ordered ice-bags for hemoptysis, believing the cold beneficial. Had seen hemoptysis in a robust engineer of 30 or 35 years, following a severe coughing spell induced by temporary laryngeal irritation. No pulmonary lesions and no arteriosclerosis in this case. Opiates, recumbency, low diet and ice locally are beneficial.

Dr. Théard hesitates to use opiates in these cases because the nausea and vomiting frequently following these drugs may induce fresh hemorrhage. The addition of atropin advisable.

Dr. Dabney.—Important to relieve cough, but whisky, opium and syrups objectionable. Opium upsets stomach and digestion, and syrups, causing fermentation, do also. Uses dilute hydrocyanic acid in nearly all cough mixtures, not in the uncertain syrup of wild cherry, but in doses of about 3 minims after an initial dose of about 6 minims.

Dr. Lemann had seen some cases of hemoptysis from passive congestion due to failure of cardiac compensation. Digitalis useful in such cases, and caution necessary in the use of morphin.

Dr. LeBeuf alluded to cases of bloody expectoration mingled with abundant mucus, and recommended strychnin as a sheet anchor in some cases.

Dr. Gessner had just had a four weeks' struggle with a case of hemoptysis in the pre-tubercular stage. Absolute rest had been ordered, even to the use of cloths for expectoration. Ice applied. Hemorrhage every 3 or 4 days. Hypodermics of morphin sulphate, gr. $\frac{1}{4}$ with atropin sulphate, gr. $\frac{1}{75}$ had been effectual in stopping hemorrhage. Calcium chloride for several days in vain. Antipyrin, 5 grs. every 2 hours with codein to relieve cough, uneffectually tried for 3 days. Codein caused some delirium. The constipation induced by opiates may cause fresh hemorrhage from straining at stool. Finally succeeded with drop doses of aconite, given every 2 hrs., night and day.

Moist gangrene might result from too prolonged ligature of extremities, though temporary occlusion of the superficial veins might check pulmonary hemorrhage. Some danger of fresh hemorrhage when ligatures are removed.

Dr. Genella called attention to the fact that only 3 limbs were ligated at a time, and explained that about every half hour a ligature was changed freeing the limbs in turn.

Dr. Dupaquier, in closing the discussion, stated that the arythmia in his second case was periodic. In such cases, if no brain disease existed, myocarditis is to be expected. Ingestion of gelatin might have benefited Dr. Blum's case. In cardiac hemoptysis the blood is bluish, blackish and clotted; in tubercular hemoptysis the blood is bright. Had seen hemoptysis without apparent lesions in a gardener after a hard day's spading. The nausea caused by opium may aid in controlling hemorrhage. Graves gave ipecac to the point of nausea for this purpose, and Fournier gave it to vomiting. Hydrocyanic acid, though good, not powerful enough for urgent cases. Constipation sometimes causes reappearance of hemoptysis. Digitalis advisable when passive congestion exists. The pinkish froth of pulmonary edema is not hemoptysis. Hypodermics of strychnin are good. Better still, is ether, or camphor in aseptic oil. The combination of atropin and morphin a good one. Aconite good, but dangerous to leave in the hands of patients.

Dr. Joachim, then *exhibited two prepared skulls.* In the first, there was a very small frontal sinus on the left side, and on the right, none whatever. The other skull was asymmetric, and a deviation of the vomer was unusually pronounced. This deformity had in life extended to the cartilaginous septum.

Dr. LeBeuf, reported a *case of peri-rectal abscess*, as follows: White female servant aged 42, a syphilitic, and formerly an alcoholic. Fell on stairs about October 1, 1900. When first seen, some 10 days later, had pain in anal region and some fever. In the ischio-rectal space was a blackish spot. The next day the spot was gangrenous, and by the following day the whole house was permeated with the odor. After curretting Dr. LeBeuf applied carbolic acid, followed by alcohol. In a week the whole pelvis became gangrenous, and a large cavity formed with the rectum hanging loosely in it, the hemorrhoidal vessels still in-

tact. Odor indescribable. Patient sent to Charity Hospital. Antisyphilitic treatment throughout. By November 12, 1900, patient was well and functional result perfect.

Dr. Barnett had just seen with Dr. Parham a *case of bilateral dislocation of the kidneys*. The left could be felt as low as crest of the ilium, and the right actually descended to the pelvis.

Dr. Perkins mentioned a single horse-shoe kidney lying over the aortic bifurcation, seen in the dissecting room.

Dr. Parham desired to call attention to *a valuable suggestion* in a recent report by Schwartz, of Agram, *on sixteen cases of spinal analgesia with tropa-cocain*. Both cocain and eucain had been found objectionable, because the after-effects, though slight, were so frequent. There was no marked difference in the disagreeable effects of these two drugs. The suggestion of the Roumanian surgeons that cocain be given prophylactically the day before using it for spinal analgesia he had found of no value. He then tried tropa-cocain, and in a series of sixteen cases found it absolutely without disagreeable effects. 3 centigrams produced analgesia as high as the knee, and 4 or 5 centicaused complete analgesia. In one case of urethral rupture the analgesia was still complete after two hours. Dr. Parham thought that the drug should be tried, as our present results with cocain are not satisfactory.

Dr. Dabney had recently seen *a patient with delirium tremens* who had been unable to sleep in spite of four doses of potassium bromide, 1 drachm each, at 2-hour intervals. Patient had not slept for three nights. A hypodermic of apomorphia gr. 1-16 was given shortly after a full meal. Emesis followed in two minutes, and in three the patient was snoring. Dr. Dabney became alarmed. Could not tell whether pulse was weak or strong. Even after an hour it was impossible to arouse patient, who slept twelve hours. Next day patient felt "rocky" vomited at the sight of a cocktail. Apomorphia of great value in treating inebriates.

Dr. Blum, when an interne at Shreveport Hospital, had given whisky followed by apomorphia to inebriates, and some cases had apparently been cured.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

Treatment of Cancer.—At the meeting of the Paris Surgical Society, February 21, 1901, M. Launois read a very interesting paper on an ulcerated neoplasm of the breast, which treated by injections of a soluble salt of quinin was considerably improved both locally and as to its constitutional manifestations. The patient was seen on two occasions by M. Poirier, who positively noticed a decided improvement. M. Berger points out the fact that there is a real improvement, but a cure is not yet effected.

M. Tuffier has witnessed a similar influence by the use of other drugs, for instance, cacodylate of soda.

M. Bazy has even observed a similar spontaneous improvement and relates such a case, recently seen by him.

M. Quenu has utilized several proposed drugs, such as quinin and the cacodylate and never noticed the slightest improvement, not even with the serum of M. Wlaief, which in one instance caused fever and aggravated the case.

M. Felizet rules thus: Following the medical cure of a neoplasm to prevent recurrence injections must be made according to M. Jaboulay's method. M. Berger said that if the Surgical Society cannot consider the doctrinal aspect regarding the serum of M. Wlaief, every surgeon ought to read and follow with interest all researches on that subject. As to the facts, M. Berger has some personal observations, and has witnessed several important points, manifest general improvement, even in the local functional condition; frequent suppression of pain and hemorrhages; unfortunately the method does not seem much to modify the essence of the tumor.

M. Nimier confided to M. Wlaief one of his patients, in whom the treatment amounted to naught.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans.

Asthma and Pregnancy.—Asthma may occur, says Audebert, for the first time during pregnancy. In some cases it may occur only during gestation and sometimes in successive pregnancies. He cites an instance in which he diagnosed a three month's pregnancy in a IV-para who was nursing and not menstruating, being led to this conclusion by a sudden attack of asthma. In such cases, he regards the occurrence of such paroxysms as a sign of pregnancy. He makes no attempt to account for the etiologic relationship of the pregnant state to asthma. At the time of labor its symptoms are much more severe and dangerous or may be absent. The mother may die (one case in seven); the fetus suffers somewhat. Fetal motions may be slow or not present for a time. In one case absence of fetal sounds for a day was noticed: subsequently, they were feeble and ceased soon after birth. The dyspnea never causes uterin contraction, but is itself increased by labor. The writer advises morphin, and local revulsion, as treatment; quinin, if the case is one of hay fever. Induction of labor is indicated, especially in the interest of the child, if the attacks are severe and repeated. During an interval rapid digital dilatation, followed by rapid extraction by forceps or version, is preferable.—*American Journal of Obstetrics*, February, 1901.

Diabetes and Pregnancy.—In a review of a thesis of A. Salemi, *The American Journal of Obstetrics* states that in two-thirds of pregnant women there occurs a glycosuria which appears during the last two months and disappears without treatment. It bears no relation to diabetes mellitus. True diabetes does not prevent pregnancy. In mild cases gestation may terminate normally at term; in acute or subacute forms abortion or premature labor may be feared. The puerperium is often prolonged. The vitality of the fetus is often impaired and it may be still born. A pre-existing diabetes usually continues

unchanged during the first half of pregnancy, and then becomes suddenly worse, the severe symptoms occurring after the seventh month. After delivery glycosuria, polyuria and polydipsia diminish, but renal and pulmonary complications are threatening. Infection is favored by the constant presence of sugar. Marriage is permissible if the woman is young, the affection just beginning and yields easily to treatment and if there are no lesions of the uterus and appendages. Repetition of pregnancy must be forbidden if the first aggravates the disease. If medical resources fail to relieve the symptoms and the life of the mother and child are in danger, induction of labor is necessary.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Black Vomit and Hematemesis in Appendicitis.—Among the most dreadful complications of appendicitis, black vomit and hematemesis are now recorded as the latest (Professor Dieulafoy, Academy of Medicine, March, 1901). All cases but one reported by the speaker were operated upon and found to be severe and advanced cases of appendicitis. All died. This illustrates once more the varied mischief appendicitis may cause and also the necessity of an early and rapid operation.

Lucas-Championnière remarks that blood vomit from toxemia due to appendicitis as reported by Dieulafoy, had in his mind, a similitude to the black and blood vomit due to severe septic peritonitis, a common danger in abdominal surgery, as, for instance, after operations for strangulated hernia, ovarian and peritoneal cancers, chiefly the latter, which favor peritoneal infection and cause oversensitiveness of the peritoneum, hence the gastric reflex. The vomit is at first green, copious and fluid, then come the coffee grounds, also copious, and finally streaks of blood, varying in quantity. Bowels are paralyzed so, no gas is passed and *post mortem* shows black matter and blood in gastric cavity, walls of which are deeply congested.

Lucas-Championnière at one time also believed that the black vomit and hematemesis following abdominal operations were fatal, but he had three recoveries, the latest in a case operated upon for appendicitis. Repeated lavage of stomach with a one per cent. solution of sodium bicarbonate and copious saline infusion (one and a half litres) did the work in finally controlling the vomiting. Hematemesis in Dieulafoy's three appendicular cases is, as stated, more pronounced and due to pyloric ulceration; but as gastrotomy is out of the question in the patient's condition, the lavage and serum treatment are even then suggested as the best, after the facts reported, not losing sight of the paretic condition of the bowels.

Lucas Championnière's remarks on other interesting points are briefly stated. He said that appendicitis is not the typhlitis or perityphlitis of old, but a new disease of the present time, since the many and varied and frequent and grave accidents and complications of appendicitis, if appenditis existed at all as it does now, would have been noted and reported by our predecessors. He attributes it chiefly to the excessive use of meat as a food and to the restricted use of purgatives, which both favor intestinal infection. The latter spreads to the appendix, the lymphoid structure of which is the open door to systemic infection. Of course, it is not denied that some infectious diseases, chiefly influenza, favor appendicular infection, but it is probably from the fact that the intestines of certain individuals, on account of the wrong habits stated, are a well-prepared field for infection.

Albert Robin, at the same meeting, spoke on this question of intestinal infection and purgatives, and with figures developed and corroborated in detail the views expressed by Lucas Championnière.—*Journal de Médecine et de Chirurgie Pratiques, 10 Mars, 1901.*

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Tropa-Cocain Hydrochlorid.—$C_8H_{14}NO.(C_6H_5CO)$ H Cl. Synonym: Benzoylpseudotropein Hydrochlorid. This alkaloid occurs with cocain and other bases in the small Java leaves;

prepared synthetically by Liebermann. Forms white needles, melting at 271 deg. C. (519.8 deg. F.), and is readily soluble in water. Tropa-cocain in 2 or 3 per cent. solutions produces more rapid anesthesia, is less toxic, and more reliable than cocain (Ferdinando and Chadbourne).

FERSAN IS THE NAME GIVEN TO A NEW IRON COMPOUND obtained from the red corpuscles of fresh ox blood, and is urged as being a most preferable form in which to administer iron, for all other forms apparently fail to give complete satisfaction. Its endorser, Dr. Adolf Jolles, of Vienna, Austria, states that it is a powder resembling chocolate and having a slightly salty taste. It is readily soluble in warm water, not coagulable by heat, passes through the gastric digestion unaltered, but is completely absorbed when it reaches the intestinal tract. It contains iron and phosphorus combined, with about 80 per cent. of soluble albuminoids. It is apparently produced by treating the blood centrifugally and adding concentrated hydrochloric acid. This forms an albumose base and an acid albumin, which latter contains the iron and the phosphorus.

One of the recent observers, who gives the details of his successful use, is Dr. James Silberstein, of Vienna, Austria, who writes "On a New Iron Preparation, Fersan" (*Therap. Monats.*, Vol. XIV, p. 369).

Another recent observer is Dr. Julius Pollak, of Vienna, Austria, who writes on "A few New Medicaments in the Treatment of Phthisis." He has used it in fifty cases successfully. (*Wien. Klin. Wochensch.*, Vol. XIII, p. 575).—Squibb's *Ephemeris.*

Department of the Ear, Nose and Throat.

In Charge of DR. A. W. DE ROALDES and DR. GORDON KING, New Orleans.

TREATMENT OF LARYNGEAL TUBERCULOSIS.—In the *Journal of the American Medical Association* of March 16, Dr. H. Fredenthal, of New York, relates his interesting experience in the treatment of this rebellious and painful disease, at the Monte-

fiore Home for Chronic invalids. He calls special attention to the recognition and vigorous treatment of that condition known as *pretuberculous laryngitis* which is the stage preceding the formation of tubercles and ulcerations in the larynx, the symptoms of which are anemia, hyperemia and swelling.

He claims that proper treatment of the larynx at this stage will prevent an outbreak in the lungs when this has not already occurred. In the anemic stage the author advises insufflations of zinc sozoiodol with sugar of milk, with applications of nitrate of silver solution 3 , sesquichloride of iron 1 to 30, and balsam of Peru with spir. vini rectificati.

In the hyperemic stage the following solution is recommended: Creosote, 5; spir. vini, 10; glycerin, 50; also applications of tannin and alum, and treatment of any catarrhal conditions in the nose and throat. In true tuberculous laryngitis four forms are recognized; tuberculous infiltration, tuberculous ulceration, tuberculous tumor, and miliary tuberculosis. The treatment highly recommended by Freudenthal for its curative and palliative value consists in the injection into the larynx of a menthol-orthoform emulsion, preceded by cleansing of the larynx and the application of suprarenal extract powder.

The suprarenal extract has the valuable property of diminishing the congestion and prolonging the anesthetic action of the orthoform.

The formula of the emulsion used is as follows:

℞ Menthol ..... 1, 5 10 or 15 parts.
Ol. amygdal. dulc ..... 30 parts.
Vitelli ovorum ..... 25 parts.
Orthoformi ..... 12 parts.
Aquæ dest. g. s. ad ..... 100 parts.
M. et ft emulsion.

This mixture is injected carefully into the larynx by means of a laryngeal syringe. Beginning with 1 per cent. of menthol the quantity is rapidly increased to 10 and 15 per cent. The effect is a steady improvement in the lesions and cessation of pain and cough. Applications of lactic acid and curettage are condemned. For the dysphagia a glass of olive oil is given before eating, and heroin is recommended as a most valuable agent for controlling the exhausting cough.

Phototherapy or the application of electric and sunlight to the larynx is mentioned favorably.

The author reports a few cases demonstrating the good effects of this line of treatment.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

At Meeting of March 19, 1901, of Section on Ophthalmology of the College of Physicians of Philadelphia, Dr. Wm. Thompson exhibited two patients presenting the Results of Extraction of Steel from the Vitreous. In one case the steel was lodged near the optic disc in a mass of exudate, and was removed by forceps and scissors in May, 1897, after location of the metal by the X-rays. It was the first case to demonstrate the accuracy of Sweet's method of localization, full details of treatment being given in a paper read before the American Ophthalmological Society in that year. At the present time the eye presents a fair cosmetic appearance. The commissure is slightly smaller than its fellow, and the ball deeper in the orbit, but the cornea is clear and bright. The iris is drawn down to the outer side, and the pupil closed to a small black streak. The eyeball is soft, but there has been no pain or tenderness. The man returned for occasional pain in his good eye, and a dull headache. There was no evidence of sympathetic trouble, the asthenopia being due to a hyperopia of + 1.25. In the second case the steel was removed by the magnet through an incision made at the corneo-scleral junction for the extraction of the cataractous lens An iridectomy and a needling of some opaque capsule were subsequently done. The eyeball at this time, six months after the accident, was free from pain and signs of inflammation. Vision equaled ⅛, with + 10 Sph. ⊂ + 5 Cyl. axis 90 deg.

Dr. Geo. C. Harlan spoke in favor of the more frequent use of the ligature recommended by Szokalsi in the Treatment of Pterygium. He had tried it many years ago with results more

satisfactory than by any other operation, but had given it up on account of the occurrence in one case of a rather serious tenonitis. Since then his routine treatment had been lozenge-shaped excision in small pterygia and the splitting and transplanting operation advised by Knapp in larger ones; always separating the point of the pterygium from the cornea by the tearing process recommended by Prince. Recently, hoping that antisepsis and ice might prevent excessive reaction, he had resorted to the ligation again, with very satisfactory results. In several cases operated upon there had been no serious inflammation, the ligated portion had separated in from four to five days, and the resulting cicatrix had been less contracted and smoother than after excision.

Discussion.—Dr. Hisley was glad that Harlan had revived the old operation for pterygium by this ingenious ligature. He had formerly employed it almost exclusively with most satisfactory results until in one case he had lost the inner half of the cornea from ulceration. He believed that the failure in other forms of operation was often due to the removal of the subconjunctiva tissue instead of confining the excision to the conjunctiva.

Louisiana State Medical Society Notes.

Twenty-Second Annual Meeting of the Louisiana State Medical Society, New Orleans, Thursday, Friday and Saturday, April 18, 19 and 20, 1901.

One of the most successful meetings of the Society was held on the above dates at the Medical Department of Tulane, Canal and Villeré streets, in New Orleans, under the presidency of Dr. Frederick W. Parham. An excellent program had been arranged, and with some slight changes in the order of it, the several sections and miscellaneous papers were concluded. The meeting was notable for the harmonious spirit throughout, and for the valuable discussions elicited. Incident to the meeting were several sets of resolutions, all pointing at pregnant questions. Notably, a protest against removing quarantine station

from Dry Tortugas; resolutions directed at recommending the establishment of a consumptive isolation home in the country and the appointment of a committee to further this end.

Here follows a resumé of the several sessions and the business done:

FIRST DAY.

MORNING SESSION.—The meeting was called to order by the President, DR. F. W. PARHAM, with a good attendance of both city and country members. Dr. H. B. Gessner, Recording Secretary; Dr. A. G. Friedrichs, Corresponding Secretary, and Dr. H. S. Cocram, Treasurer, were also present.

The minutes of the last meeting were next read and the President called upon the Committee of Arrangements for a report. Through the chairman, DR. ISADORE DYER, the committee stated that the program submitted covered their report. Beginning in the Fall, chairmen of sections and openers of discussion were notified to send in subjects for their sections. With the November number of the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, notices of the meeting were published and the program outlined from month to month until it was considered complete enough to be issued in a preliminary sheet. This was done in early March. The final program was mailed so as to reach each member several days before the meeting. The committee announced that the members of the Society were invited to a lunch at the Polyclinic after the morning session, and to a banquet at the St. Charles Hotel on the night of its last day.

The Treasurer, Dr. H. S. COCRAM, reported that the expenses of the past year had been $1700, about $400 more than the year previous. The cash balance in bank is $425, with sixty-five active members in arrears for the dues of 1900.

Some discussion followed as to the method to be adopted for the collection of dues of delinquents, and this resulted in the motion that the treasurer have a list of delinquents in evidence at each meeting.

The Recording Secretary, DR. H. B. GESSNER, then read his report embodying the following:

"We have left now, after the removal from the roll of members who have died, resigned, been dropped for nonpayment of dues or who have never qualified for membership, a total of 267 active or permanent members. We have a total of 51 applicants

eligible this year, eight whose applications will have to remain on file until 1902 because they were handed in less than a month before this meeting. I need not again call your attention to the relative meagerness of our membership list. I believe that a larger membership, which will give us the strength of numbers and a proportionate bank account, can be built up permanently only by the preliminary building up of parish or district societies, which will keep up interest in medical organizations throughout the year. I believe that a sum of money placed in the hands of the committee on organization each year, for paying the traveling expenses of vice presidents while making visits through their districts for this purpose, would bring in large dividends in the shape of membership fees. In connection with these fees I would suggest striking out the phrase 'and accompanied by the annual fee' from section 8, article II of the by-laws. The regulation requiring the annual fee to be sent with an application has not been enforced for some years. It was not being enforced when I came into office, and I have not departed from custom in this regard, although the fee has been accepted when sent by an applicant. For the sake of uniformity it would be well to strike out this provision and not receive a fee in advance from any one, unless the Society thinks best to have the rule enforced."

The President read the report of the Committee on Organization, the chief question in which was the fact that of over 1500 physicians in the State, only 267 were members of the Society.

The President's Report embodied reference to the Dry Tortugas Quarantine Station, "which," he said, "was about to be transferred from the control of the Treasury to the Navy Department, which means its establishment as a coaling station and its abandonment as a quarantine and dispensary station. The State Board of Health of Florida and the Florida State Medical Association have already protested, and it is of great and vital importance that we enter a strong and formal resolution against this contemplated action of our government. I am assured by Dr. Murray, the surgeon in charge, that it is an extremely useful station to us, affording a safe refuge to all infected ships with the least hardship to commerce, and both Dr. Souchon, President of the Louisiana State Board of Health, and Dr. Kohnke, President of the City Board of Health, indorse

this view. If our voice can aid in the retention of this station as a quarantine station we should utter our sentiments in no uncertain tone."

Attention was called to American Medical Association meeting at St. Paul, in June, with the remark that Southern physicians should take more interest in this gathering.

Dr. A. G. Friedrichs, Corresponding Secretary, presented a tabulated statement of the physicians in the State, showing the names of 138 physicians practicing without a license and 1358 regular physicians. His report named nine homeopaths and eleven eclectics in the State.

Committee reports were then made, where chairmen or their representatives were present.

For the Committee on State Legislation, Dr. H. D. Bruns reported that the law creating boards of health in the parishes had been amended so that one year's residence now suffices instead of five years as heretofore.

A resolution was adopted favoring the establishment at Washington of a laboratory, under federal control, for the application of physiologic psychology to sociologic and abnormal or pathologic data as found in institutions for the criminal pauper.

In the absence of the author, the secretary read the paper of Dr. H. J. Parsons, of Minden, La., on *Overaction of the Heart from Hyoscin*, which was discussed by Drs. Hays, F. M. Thornhill and Thompson.

Dr. J. M. Barrier, of Delhi, then read a most interesting paper on the *Uses of Strychnin.* [To appear in June number of the Journal.] The paper was well discussed and brought out the point that strychnin could be given in very large doses in cases of pneumonia, hematuria, etc. The discussion was carried on by Drs. Seay, Dabney, Paine, McGehee, Oechsner, and R. W. Carruth.

An expression of thanks was tendered the author for his paper.

On adjournment the members of the Society were regaled with a buffet lunch at the New Orleans Polyclinic building, where the time was pleasantly spent until nearly time for the afternoon session.

Afternoon Session.—Called to order at 2:30 p. m. promptly by the President. The regular program was taken up, the Sec-

tion of Surgery being called. Dr. E. D. Martin presented the subject of *Fractures of the Long Bones of the Upper and Lower Extremities.* [Paper to appear in Journal.] Especial attention was called to the suspension splint apparatus, modified after Hodgen's method, and to the repair of fractures with the staple. The doctor showed a special instrument for driving the staple into the bone, this being based upon the principle of the instrument used by bookbinders for driving wire through paper in binding.

Dr. R. Matas opened the discussion of Dr. Martin's paper. He said he wished to submit a contribution of statistics on fractures at the Charity Hospital for a period of ten years, from 1886 to 1896. In all there had been 2376 fractures during that time, out of a population of 69,000 who were treated in the wards. Of the total fractures 378 were of the head, or 16 per cent. of the total number.

He reviewed the methods in vogue, and in general terms did not approve of metallic devices. He asked for some opinion regarding the Playfair splint.

Dr. Parham had not found the Playfair splint of service.

Dr. Bloom believed metallic splints of service in many cases.

Dr. Martin closed the discussion.

Dr. O. Joachim, of New Orleans, followed with a paper on *Otitis Media Neonatorum* [to appear in the Journal], which was freely illustrated with well prepared specimens.

Dr J. A. Storck, of New Orleans, then read an interesting paper on the *Effects of Alcohol on Digestion* [to appear in the Journal.] He dilated upon the harm done by the use of alcohol in healthy persons, and considered it wasteful. In disease alcohol was of value and a stimulant to digestion; this was especially true of champagne.

Dr. E. M. Dupaquier, of New Orleans, discussed the paper and argued that the use of alcohol dulled the appetite instead of increasing it. He referred to instances in point.

The Section on Genito Urinary Surgery was next called for and Dr. Charles Chassaignac, the chairman of the section, read a paper on the *Treatment of Cystitis.* A review of the varieties of the disease based on the pathology and etiology was presented and the treatment as practiced by the author and by others was given.

The discussion was carried on by Drs. Felix Larue, E. M.

Dupaquier and W. M. Perkins, of New Orleans, and Dr. R. B. Paine, of Mandeville.

Evening Session.—Dr. O. M. Patterson, the vice president of the Fifth Congressional District, called the meeting to order. He introduced Dr. L. H. Warner, of New York, pathologist to the New York Skin and Cancer Hospital. Dr. Warner was on his way to the Texas meeting at Galveston, and had been persuaded to deliver a lantern slide lecture on blood specimens. The lecture was much enjoyed both from the beauty of the specimens exhibited and for the explicit explanations of the speaker. While syphilis was the main theme, the malarial, icteroid and other blood specimens were demonstrated. Special stress was laid upon the diagnostic quality in the blood of syphilis and Justus' test was described. The speaker dilated upon the Lustgarten bacillus and presented specimens to substantiate the argument that the frequent concomitation of malaria with syphilis produced the presence of a modified malarial organism which was identical with the Lustgarten bacillus. At the conclusion of the exhibition (on motion of Dr. G. A. B. Hays) a vote of thanks was tendered Dr. Warner for his remarks [to appear in full in the Journal].

Dr. E. A. Robin, of New Orleans, chairman of Section on Ophthalmology, then read an elaborate paper on *When Not to Operate in Anomalies of the Extrinsic Muscles of the Eye.*

Dr. P. L. Reiss, of New Orleans, discussed the paper and urged conservatism in operating on eye muscles. The conditions were often relieved by treatment with tonics, and by the use of glasses. Cases at first unyielding, in his experience, after a time would respond to non-operative procedures.

Dr. H. D. Bruns, of New Orleans, endorsed the views of the writer of the paper and therefore found no room for a discussion.

The Section on Materia Medica and Therapeutics was next called, and the chairman, Dr. L. Sexton, of New Orleans, read a paper entitled, *Is the Tendency Toward Prescribing Proprietary and Patent Medicines Increasing;* and its *Final Effect upon the Professions of Medicine and Pharmacy.* Attention was called to the enormous increase in the number of patent medicines in the last ten years (some 500 per cent). Nearly 3000 unofficial drugs were on the market and growing in number every day, and the profession encourages the increase by endorsing these remedies.

Dr. Sexton spoke of the common use of the coal-tar remedies being often given for headache and other pains to patients, who were already cyanotic from heart disease; death would often ensue and be attributed to heart failure or other causes, when, in fact, the patient thus suffering should not risk even the smallest doses of such remedies.

As a rule, too many medicines are given and taken anyway. It is only after a case has been thoroughly analyzed, after a careful examination by a competent physician, that any medicinal agents should be used. While condemning in unqualified terms the prescribing by doctors of proprietary and patent medicines, he said that because the majority of them were bad we should not condemn all, and that much of the advance in therapeutics had been made by a number of our leading drug manufacturers throughout the United States. He closed by saying that we should set unqualified condemnation upon the average nostrum that is left in our office as better suited to our waste baskets than the stomachs of our patients.

The discussion which followed was quite pertinent and spirited.

Dr. Storck blamed the doctors for the use of patent medicines and believed that the ignorance of the Pharmacopeia by the average physician was at the bottom of it. If the doctor would consult the Pharmacopeia and Dispensatory, he would find that the official list of drugs and compounds would cover all of his needs without the recourse to patent medicines and substitute remedies from drug concerns.

Dr. Dyer emphasized the point of the druggist fathering patent medicines, often of his own compounding, and the sacrifice of the physician meantime. The lack of qualification of the average druggist and his carelessness and inattention were strong factors in the present use of proprietary, or "ready made" preparations, by physicians.

Dr. J. M. Barrier, of Delhi, said the country doctor was even more responsible than the city physician, because he must dispense many of his own drugs. In the last three months a dozen enterprising agents have visited his office and asked him to give such and such a medicine a trial. The custom is creating a mental inertia among Louisiana physicians. Legislation will not correct it; the doctor must correct the habit by not patronizing the ready-made, hand-me-down prescriptions.

Dr. Hawkins did not entirely coincide with all the kicks on proprietary medicines. He had never recommended the use of a bottle of patent medicine, but he thought a great deal of both proprietary and patent medicines were used in the parishes.

Dr. F. M. Thornhill, of Arcadia, spoke to the point. As physicians it would be necessary to take some steps to prevent druggists from repeating prescriptions.

Dr. A. F. Barrow, of St. Francisville, thought the fundamental principle had not been touched. The secret of the trouble is that the proper restrictions by law do not prevail. The national government must take charge of the manufacture of drugs.

Dr. L. H. Warner said physiologic chemistry had been neglected.

Dr. Sexton closed the discussion, and referred to some of the mongrel preparations on the market, the very names of which were enough to condemn them.

The next paper called was that by Dr. E. D. Newell, of St. Joseph, on *Thirty Cases of Lobar Pneumonia with Twenty-nine Recoveries.* Some discussion followed by Drs. Barrier, Carruth and others.

At 11 p. m. the meeting was adjourned.

Second Day.

Morning Session.—The meeting was called to order promptly at 10:30 by President Parham.

Dr. Sexton read a letter from Dr. John N. Thomas, of the Louisiana quarantine station, and chairman of the Section on Quarantine. Dr. Thomas stated that he could not be present, but he urged a full and complete discussion of the subject: "Period of Incubation of Yellow Fever." The station had a case of yellow fever last year to develop in four days and six hours from the last probable exposure to infection. The patient was a sailor on the steamship Hugin, from Vera Cruz.

The case was unmistakable, and was seen by Drs. Aby, Bayon and himself.

"Therefore," added Dr. Thomas, "I am thoroughly satisfied that a detention of less than five days after disinfection of vessels from yellow fever ports is fraught with the greatest danger."

Speaking of bubonic plague, Dr. Thomas said there need be no fear of the disease gaining a foothold among clean, civilized people, if ordinary sanitary regulations are observed. Rats are so peculiarly liable to plague that it is often called the rat disease, and rats are the principal means of importing the infection.

The doctor recommended that when ships arrive from the so-called plague ports, with all well on board and with healthy rats, they be given free prâtique, after a thorough disinfection. Dr. Thomas feels sure that New Orleans is in no danger from the bubonic plague.

Communications were taken up, and one was read from the Shreveport Medical Asssociation, delegating Dr. W. L. Egan as their representative. He was present and was accredited.

The question of an isolation camp for consumptives was considered upon the following resolution of Dr. W. Glendower Owen, of White Castle.

"Whereas, the movement inaugurated advocating the restriction of consumption, through the establishment of a sanitarium, meets our hearty approval;

"And whereas, this society has repeatedly placed itself on record as being in favor of curtailing the ravages of the disease by scientific methods;

"And whereas, the co-operation of this society in an advisory capacity has been requested;

"Be it resolved, That the Louisiana State Medical Society hereby expresses its cordial indorsement of the movement.

"Second, That an advisory committee, consisting of one member from each parish, be appointed to represent the society; that this committee be selected by the nominating committee."

Dr. L. Sexton spoke on the question at the request of President Parham. He said statistics showed the mortality of consumption to be very heavy because of the squalor and unsanitary conditions in which a large per cent. of the population live. The open air treatment is the best. Georgia has its Thomasville, New York has her Adirondacks, Arizona has her health resort and Louisiana has within her borders as fine natural conditions—an ozone belt—as effective as can be found anywhere on God's green earth. Covington, La., never had but one native case of consumption. The Tchefuncta river should be to

New Orleans what the Hudson river is to the City of New York. It is a delightful country for poultry raising, dairy farming and other outdoor work, which can be pursued by the patients who are suffering from the early stages of the disease.

Dr. Pigott, of Covington, said he had been practicing in St. Tammany for ten years and he knew of but one native case of consumption.

Dr. F. J. Mayer, of Opelousas, favored the Owen resolution. He said the commercial and insurance companies all over Germany were erecting sanitariums in order to care for consumptives, rather than let the disease take its course. He thought we should look after consumption cures from a commercial standpoint. Consumption is the great white plague. There are two ways to fight it; first, by education of the people; second, by the establishment of proper sanitariums, places where the poor can receive the benefits and at the same time not give up their occupations entirely. The consumptive is not the victim of hereditary taint, but the victim of an unsanitary community.

Dr. O. Joachim told of the experience of Massachusetts, where there was a public sanitarium, and he thought Louisiana could not do better than follow in the wake of the Bay State.

Dr. W. L. Egan, of Shreveport, thought the resolution only partially covered the case. He objected to isolating all diseased. As a treatment the plan was good, but as a prevention it was insufficient. This Society should try to prevent consumption as well as cure it.

Dr. N. M. Hebert, of Covington, had seen many cases of consumption come to the belt, and every one had been benefited.

The resolution was passed.

Dr. McGehee, chairman of the judiciary committee, reported that fifty-two applicants for membership had been received into the society, only two being rejected. The following are the new members elected:

J. S. Allison, Swartz, La.; L. B. Arcenaux, Church Point; P. L. Bellinger, Waterproof; H. L. Ballome, Diamond Post-office; J. G. Bouvier, Jeanerette; W. A. Burleigh, Fordoche; J. L. Burthe, New Orleans; I. M. Calloway, Shreveport: C. D. Clark, Mer Rouge; S. M. D. Clark, New Orleans; J. H. Cooper, Welsh; O. Czarnowski, New Orleans; Jos. Conn, New Orleans; L. de Poorter, New Orleans; C. F. Duchien, Baton Rouge;

Homer Dupuy, New Orleans; J. A. Estopinal, Estopinal Postoffice; M. W. Feingold, New Orleans; S. J. Gates, Franklin; L. A. Gaudin, Convent Postoffice: W. A. Gillaspie, New Orleans; F. E. Girard, Lafayette; R. R. Grant, Rosedale; S. D. Gustine, Kenner; J. B. Guthrie, Jr., New Orleans; J. E. Heidingsfelder, New Orleans; Lee Henry, Lecompte; E. S. Kelly, New Orleans; W. H. Knolle, New Orleans; A. A. Landry, Paintcourtville; F. Loeber, Jr., New Orleans; S. Logan, New Orleans; D. U. Maes, New Orleans; M. C. Melançon, Jennings; C. Menville, Houma; D. D. Mims, Minden; D. McAnn, Knox Point; R. E. McBride, Houma; A. Nelken, New Orleans; J. C. Oden, Logansport; J. I. Richard, New Orleans; Thomas A. Roy, Mansura; Wofford Sanders, New Iberia; V. U. Schayot, Pointe-á-la-Hache; W. H. Seemann, New Orleans; V. C. Smith, Henderson Postoffice; N. C. Stevens, Ama; E. O. Trahan, Whitecastle; H. E. Walet, New Iberia; E. B. Young, Lindsay.

Dr. C. J. Landfried, vice president for the First Congressional District, chairman of the committee on organization, read the report, making a number of interesting suggestions.

The recommendation of the president, that the Society should make formal protest against the abolition of the Dry Tortugas quarantine station, gave rise to the appointment of a committee, composed of Drs. LeBeuf, Nolte and Newell, to report later.

A communication was read from Dr. H. S. Cocram, resigning his place on the Board of Medical Examiners. It was accepted with regrets, and the vacancy referred to the nominating committee.

Afternoon Session.—When the meeting had been called to order the Section on Sanitary Science was called and Dr. E. Souchon, of New Orleans, read a paper on *The Prevention of the Spread of Contagious Diseases.*

He reviewed epidemic years of fever and gave his personal experience of how best to handle clothing and household goods, where contagion exists. Disinfection is a sheet anchor, and eternal vigilance is the price of success. The room is the battle ground.

Dr. Archinard wished to add one point, and that was that the spread of disease is too often caused by the ignorance of the practitioner on the subject of disinfection. Instead of ten minutes' boiling, he thought one hour was necessary.

Dr. G. C. Mouton, health officer of Rayne, spoke of their small-pox experience in Acadia parish. He had found bichloride of mercury very successful in disinfection.

Dr. Quitman Kohnke, president of the City Board of Health, said he was impressed with the thoroughness of the measures advocated by the State health official. So far as carrying out all the suggestions in detail, he thought it only an iridescent dream that could not be put in every day practice. While sulphur disinfection is not entirely adequate, yet the rooms, after being filled with the fumes, must be thrown open to fresh air, which will do much towards disinfection.

Dr. F. J. Mayer, of Opelousas, spoke of formaldehyde gas and he wanted to know whether it had proven efficacious or not; whether its penetrating qualities were sufficiently powerful.

Dr. G. W. Remage, of Jennings, detailed some of his vaccination experiences in Calcasieu parish seven years ago; how vaccination had done much good, even when administered after exposure.

Dr. Souchon closed the section by saying that the education on disinfection must begin at home—*i. e.*, with the doctor.

Under the Section on Obstetrics and Gynecolgy, Dr. E. S. Lewis, the chairman, read a paper *On Lacerations of the Cervix and their Consequences.* An elaborate review of the subject was given with the clearness characteristic of the author.

Dr. P. Michinard, of New Orleans, opened the discussion, taking up chiefly the consideration of the lacerated cervix as the cause of cancer. His experience negatived any such conclusion and he quoted Emmett freely as emphasizing this view. Some attention was given to operative procedures for the relief of lacerations and the detail of special technic was related.

Dr. Lewis closed the discussion.

The Nominating Committee then made its report, through its chairman, Dr. W. G. Glendower Owen, recommending the following officers who were duly elected:

President, Dr. T. E. Schumpert, of Shreveport.

Dr. F. A. Larue, vice-president first congressional district, New Orleans.

Dr. E. D. Martin, vice-president, second congressional district, New Orleans.

Dr. G. W. Remage, vice-president, third congressional district, Jennings.

Dr. I. M. Calloway, vice-president, fourth congressional district.

Dr. J. M. Barrier, vice-president, fifth congressional district, Delhi.

Dr. A. F. Barrow, vice-president, sixth congressional district, St. Francisville.

The committee reported the names of Dr. L. G. LeBeuf and Dr. E. L. McGehee to be selected members of the Board of Medical Examiners, in place of Dr. H. S. Cocram, resigned, and Dr. B. A. Littell and Dr. A. F. Barrow, members of the board of medical examiners, in place of Dr. A. F. Barrow, whose term is to expire.

The committee recommended that the next meeting of the association be held in Shreveport. Objection was raised to this portion of the report on the ground that a former resolution of the Society had made New Orleans as a permanent domicile of the association.

Dr. H. Dickson Bruns moved that the rule be suspended for the coming year, and that Shreveport be selected as the next meeting place. It was seconded by Dr. Barrier and was carried.

The date was chosen for the first week of June, Tuesday, Wednesday and Thursday, June 4, 5 and 6, one year hence.

The new officers were called upon for speeches. Dr. Schumpert, the president-elect, said Shreveport would give the Society a royal welcome, in both a scientific and social way.

Dr. J. M. Barrier, vice president from the Fifth Congressional District, was vociferously called for. He is from Richland parish, and he responded in a humorous vein. The doctor dwelt upon the poetic bayou Maçon, the cotton that grows as tall as trees and mosquitoes that reach the dimensions of a rabbit—to this lovely spot the new vice president invited the Society.

The regular program was then resumed. Dr. O. Joachim, as chairman of the Section Otiology, Laryngology and Rhinology, started the symposium on the topic, "*The Middle Ear Inflammations of Childhood and their Consequences.*"

Dr. Gordon King in discussion took up the general subject, applying it to "*Deafmutism and the Causes.*"

Following him came Dr. O. L. Pothier, on the subtopic, "*Patholoy and Bacteriology.*

Dr. J. P. O'Kelley read a paper on "*Symptoms and Treatment of Acute and Chronic Middle Ear Inflammations.*

The meeting then adjourned.

Evening Session.—A special program had been prepared by the Arrangement Committee consisting of purely literary papers and demonstrations.

The retiring President, Dr. F. W. Parham, of Orleans, read a scholarly review of *Superstitions, Fads, Fetiches and Facts; a Retrospect and a Forecast; the Lines on Which the Progress of the Future Must be Worked out*

Dr. Parham said, "We are accustomed to look upon the middle ages as the dark period in history, filled only with myths and superstitions, but we must admit that much of it has descended to us through the centuries. The belief in witches was not confined to the ignorant.

"The Arabians used to write with a purgative ink certain charms in cups in order to purge the faithful mysteriously."

Taking up the work of modern homeopathists, the speaker said, in spite of their remarkable cures, the apparent simplicity of the school's therapeutics, the influence of the order is on the wane. The worst abusers are to be found among the homeopaths themselves.

After reciting a number of cases, the speaker said the homeopathic house is divided against itself, und as the years pass we find the pure homeopathists becoming beautifully less and less, until, as shown by the reports before this convention, only nine homeopaths are now practicing in the State of Louisiana.

Dr. Parham dwelt at length on the subject of homeopathy and declared that it was a system built up on absurd foundations. He said it had had every opportunity, and its influence first disappeared in Europe, and now at last in America.

"Shall we not, however," said Dr. Parham, "give homeopathy the benediction as she goes, and thank her for her assistance in the battle against poly-pharmacy, which is still being waged by the adherents of scientific medicine? Homeopathy has served its purpose; it has enabled us to observe the natural history of disease.

"Even Christian Science can not altogether be tabooed. We surely all recognize something of value in hypnotism, however much of imposture there may be of it, even in our own ranks,

and however great the danger may be of pushing it beyond the bounds of reason until it shall become little better than the old mesmerism and other forms of animal magnetism. Do we not all make use of a silent hypnotic influence over our patients? The real crime of Christian Scientists lies not in what they do, but in what they do not do."

Dr. Parham then took up the Christian Scientist as he deals with consumption, and he thought it time to stop the wholesale destruction of innocents by the Christian Scientists, especially in view of the fact that the percentage of cures in San Antonio are growing greater every year, the cures ranging from 60 to 80 per cent. In the United States consumption kills every year 164,250 persons, or at the rate of 450 daily. We are justifiable in using the therapeutics of Christian Scientists, but the imposture and fanaticism of their horrible creed must be combated by every force at our command.

"But what shall we say of the osteopath?" asked Dr. Parham. "Of what he has of value to offer let us also freely avail ourselves, but we must resolutely oppose his charlatanism. As it was once stated in the New York General Assembly, charlatans first try their treatment on public men in order to use their names. Patent medicine men first try their drugs on clergymen who are trained to accept things by faith. Responsible physicians first try their theories on the dog."

Dr. Parham argued that what we want in medicine is keen Hippocratic observation and a truthful statement of facts. All progress must be along this line.

After all, disinfection will never take the place of fresh air in the purifying of rooms occupied by persons suffering from infectious diseases.

In summing up his address to the society, Dr. Parham said:

"We must as rapidly as possible give up our fetiches and deal only in facts. We must from time to time take an inventory of our knowledge. Let us put theories in the background as did Bichat, or rather let us make our theories fit our facts; not lay our facts in the Procrustean bed of theories. Let us hold fast to all that is good, and discard once and forever all that is chaff and false. Let us remember that in all so-called new systems old principles re-appear and that the labors of the past are not sufficiently consulted to guard against the revamp-

ing of theories that had long ago been proved altogether futile. But let us above all, take care of the facts, and the theories will take care of themselves. We need a more united profession.

"Our motto is too much every man for himself and the devil take the hindmost. The profession of this city and State needs a large reference library. Men here are discouraged from exhaustive research, not so much by climate, which has, I believe been much overrated, but by lack of proper medical stimulus. Nothing would, I believe, do so much as a good liberal library. We must progress from the known to the unknown. Unless we find out what has been done we will be continually discovering facts which we afterwards shall find accurately described in some dusty volume on the shelves of a good library. How often this is done is shown by the number of new operations brought out as new. Witness the Trendelendburg operation for saphena varix, recently attributed to the surgeon of Bonn, when a hunt into the literature would have disclosed an equally good description of the procedure in 1840.

"Then, too, a careful search of literature would often bring to light many facts which, without such industry, would lie buried for years. The late history of spinal analgesia is a notable case in point. Years ago we should have been where we are now and the field and limitations of these methods of analgesia would now be established. Recently, gentlemen from the Chicago and Columbia Universities told us how they had built up their libraries and how they found them the life and inspiration of the schools. We need one here and we ought to get together and have one. The medical department has one, the Parish Society has a splendid beginning of library of current literature and the Charity Hospital has some rare and valuable books. "If all these could be collected into one building, the gain would be great, but as this is impracticable for various reasons, much good could be accomplished by cataloguing in multiplex form and exchanging catalogues one with another. As to our poor State Society library, our library committee informs me that it has so far found no book to keep. This Society ought also to do its part in the collective investigation of disease. One hundred cases well observed and carefully reported upon would give us more real information than a hundred desultory discussions of the subject. The subject of continued fevers has never

been properly investigated with us, and see what possibilities are opened up to us by the discovery of the role played by the mosquito in malarial and yellow fevers. I submit these and other similar subjects for your consideration."

Prof. Geo. E. Beyer, professor of biology in Tulane University, was then introduced, and delivered a masterly and analytic paper on *Mosquitoes and their Relation to Disease*, with free illustration from colored drawings made by him; the life history of the mosquito was traced in the culex and anopheles varieties. A careful discussion was made of the morphologic changes in the blood upon the invasion of the mosquito. The way of transmission of disease through the economy of the mosquito was freely related.

Of particular interest was the statement that uncommon varieties of the mosquito had been found in Louisiana, and that new varieties to this country had been found here by the author and Dr. H. A. Veazie, of New Orleans.

At the conclusion of the paper a vote of thanks was tendered Professor Beyer, and he was unanimously elected an honorary member of the Society.

Then followed a truly enjoyable exhibition of color photography by Dr. A. L. Metz, professor of Chemistry, in Tulane Medical Department. Both the Ives' method and the Jolly process were shown; the speaker demonstrated the theory of each and then presented beautiful examples of the actual operation. Luscious fruit, beautiful flowers, attractive landscapes were shown in turn, each in its natural colors. Iridescent pottery, the interior of conservatories with the reflecting rays of sunlight, and the flesh tints of persons photographed, were all well brought out.

The practical applicability of this mechanism was demonstrated by the presentation of examples of some common skin affections, showing color differentiation, by the microscopic photograph of polarized crystals and by the demonstration of specimens of mineralogic specimens, those of the agate and carnelian showing each separate color in their several beautiful strata.

At the conclusion of these interesting pictures, Dr. Metz gave a few experiments with liquid air, first briefly outlining its history, giving due credit to Professor Duer for his experi-

mental work; he indicated the gradual evolution of the substance, until to-day it is a commercial substance of easy production and of cheap enough price to make it practicable in the arts and sciences as well as in every day use. He prophesied that shortly this product could be had at one cent a gallon. The experiments were most interesting; first an elastic ball was kept in the liquid air for a few minutes and then became as fragile as glass; a carnation dipped for a few seconds in the liquid became so fragile that it splintered almost on touching it; mercury froze solid at the temperature of 312 degrees represented by the liquid; likewise alcohol. The liquid air boiled on a cake of ice and when water was poured in the vessel in which the air boiled it, the water, froze solid. A hammer of mercury frozen to a stick drove nails easily without fracture of the mercury. Other experiments were made, all interesting, and this concluded the evening session, not, however, before a cordial vote of thanks was tendered Professor Metz for the lecture he had prepared and delivered.

Third Day.

At 8:30 A. M. Dr. Martin operated at Charity Hospital before some of the members of the Society to demonstrate the method of *Spinal Anesthesia.*

The Morning Session was called to order at 10 o'clock.

Dr. E. Souchon offered a resolution to abolish the Section on Sanitary Science and recommending that it be combined as heretofore with the Section on Quarantine. This resolution was adopted.

Dr. J. J. Archinard, chairman of the Section on Bacteriologye submitted his paper on the *Birth and Progress of Bacteriology* and asked that it be read by title. He then elaborated the subject with a running description of several and various microorganisms in sequence, using the stereopticon for his demonstration.

Dr. H. B. Gessner opened the discussion, taking up the surgical feature of the subject.

The discussion was followed by Drs. Martin, Dupaquier and Parham.

At this juncture the chair called for the report of the committee appointed upon the corresponding secretary's report, and the chairman, Dr. C. J. Landfried, of New Orleans,

responded. In brief he said that there were 537 doctors practising in New Orleans and 1038 in the parishes, making a total of 1575 practitioners in the State of Louisiana. There were 45 irregulars, all in the parish of Orleans. Fourteen parishes in the State are not represented in the State Medical Society.

The Section on General Medicine was next called, and Dr. W. Glendower Owen, of Whitecastle, read a most interesting paper on *Scarlet Fever*, which brought out one of the most extensive and profitable discussions of the entire meeting.

Dr. T. S. Dabney, of Orleans, spoke of the dangers of convalescing cases, especially where they had been mild. Speaking of the scaling, he suggested the use of bran in the bath as serving a double purpose, of causing the scaling to more rapid exfoliation and as soothing the skin of the patient.

Dr. F. M. Thornhill, of Arcadia, followed with the remark that the last two years scarlet fever had been uncommonly frequent in his district.

Dr J.M. Barrier related two cases in which he thought it might be scarlet fever but he was not sure. He was not quite sure about these cases anyhow. When in doubt, the diagnosis of roseola is useful. He believed in the vis medicatrix naturæ and thought that medicines were of questionable value in scarlet fever.

Drs. E. D. Newell, of St. Joseph, J. Barnett, W. Scheppegrell, P. E. Archinard, W. E. Brickell and Q. Kohnke, of Orleans, continued the discussion, bringing out various points in the diet and treatment, as well as the usefulness of treatment of the throat by gargles and sprays, the latter receiving the commendation of the majority. The question of sulphur dioxid came up in question and Dr. P. E. Archinard condemned it as not sufficiently powerful in infectious diseases and considered formaldehyde gas the best of all disinfectants. Dr. Paine, of Mandeville, spoke of the reckless danger in the practice of parents who are quite willing to have the children contract the diseases "going about" while they are young. No more potent occasion for epidemics exists.

In closing the discussion, Dr. Owen called attention to the fact that the current interest in such a subject made it open to discussion and that discussion could always be provoked if chairmen of sections would select familiar subjects.

The Judiciary Committee reported upon the name of Dr. Lytton at this juncture, which provoked a discussion as to whether

he was registered or not. Action on his name was deferred until the afternoon session in order that this fact might be ascertained. This gave rise to the motion by Dr. Larue, of Orleans, that no physician can become a member of this society until he has complied with the regulations of the Board of Medical Examiners and also has registered at the Board of Health office in accordance with the State laws. Carried.

Afternoon Session.—In the absence of regular program, the president declared that he would take up unfinished papers and sections as they might be ready in order to finish the program.

Dr. E. M. Dupaquier, of Orleans, read a paper on *Clinical Tests of Cacodylate of Sodium*. He clearly brought out the use of this drug in disease, giving something of its history and the way of its preparation. The paper evidenced great care in its preparation. The application of the drug in some particular diseases was discussed and the dosage as practiced by the author and others. Finally, the author suggested the unreliability of all preparations and suggested the use of a freshly prepared sodium cacodylate when it is to be prescribed.

The discussion of the paper brought out the impression that the drug was not a familiar one, showing that the reader had presented a timely topic.

The Section on Dermatology was next called. Dr. Roussel, the chairman, was not present, so his paper on *Dandruff; Its Treatment*, was read by title. Dr. Dyer opened the discussion with a paper on *Dandruff; Its Limitations and Complications*. He had read Dr. Roussel's paper and disagreed with the view therein that dandruff was difficult of cure. Hygiene was the chief factor. The parasitic nature of the disease compelled attention to the use of a clean hair-brush, and legislative act should direct cleanness of the shops, barber and hairdressing. Two or three per cent. resorcin applied every day, the disuse absolutely of a brush and frequent washing of the head would cure dandruff in three weeks usually. Seborrheic dermatitis, the other name for dandruff, carried about 10 per cent. of the skin diseases usually observed in its train. Even cancer may be determined by the scaling of a seborrheic patch.

Some discussion followed on the part of Drs. Dupaquier, LeBeuf and Genella, of Orleans, on the points of disinfection of brushes, hot water and massage of the scalp, etc.

A paper on *Vital Statics in Louisiana* followed by Dr. G. Farrar Patton, Secretary of the State Board of Health. Besides other points, the speaker deplored the fact that, until recently, there had been no legislation to compel the forwarding of the records to any given point for compilation. Act 162 of 1900 provided for this, and it is expected that, at an early date, the very necessary statistics can be furnished. He was sure that these statistics would bear evidence as to the healthfulness of the State of Louisiana.

Dr. A. F. Barrow related a case in which the use of saline solution brought returned consciousness. The report brought out extended discussion, in which Dr. C. Jeff Miller, Dr. Genella, Dr. Dupaquier, Dr. McGehee and others took part.

Dr. C. Jeff Miller read an ably prepared paper on the subject: *Symptoms of Extra Uterine Pregnancy.*

Science and Pseudo-Science in Medicine by Dr. T. S. Dabney, *First Help in Cases of Contagious Diseases* by Dr. C. L. Horton, and *A Case of Abdominal Pregnancy*, by Dr. L. C. Stirling, of Baton Rouge, etc., were read by title.

Dr. L. G. LeBeuf read an interesting paper on *Ptomain Poisoning in Children*, bringing out the importance of recognizing these factors in child diseases.

Dr. J. J. Archinard, Orleans, briefly covered the points in favor of *Disinfection from a Purely Practical Point of View, a Problem for Solution.* (See leading article this Journal.)

Dr. C. J. Gremillion, of Alexandria, read papers on *Malarial Polyneuritis*, and *Acute Malarial Remittent Fever Treated with Large Doses of Arsenic.*

Dr. T. E. Schumpert, of Shreveport, reported *A Case of Spina Bifida.*

The following papers were read by title and referred to the Publication Committee:

A Case of Congenital Malformation of Penis, by Dr. R. W. Seay; *Boards of Lunacy, Etc.*, by C. D. Simmons, of Dutchtown; *Predisposition to Disease*, by Dr. R. W. Walmsley; *Descemetitis or Serous Iritis a Symptom, etc.*, and *A Case of Foreign Body Removed From Eyeball by a Giant Magnet*, by Dr. H. D. Bruns.

At the conclusion of the regular program, resolutions were offered as follows:

By Dr. L. G. LeBeuf, seconded by Dr. E. D. Newell:

"We desire to express our strong disapproval of the removal or proposed discontinuance of the United States Quarantine Station at Tortugas, and we believe that we have a right to voice our opinion on this important subject more than any one else, as we are situated at the very gate of this great valley. We should strengthen our barriers and means of prevention against all contagious and infectious diseases, which may be introduced through our gulf coast. Tortugas is the first sentinel in our line of defence, and if that is lost our serried ranks are broken, our flanks are exposed, as it were, and the risk of transmission of tropical affections much greater to the country. Hence it is suggested that this be embodied in a motion of disapproval, which would be presented to our Senators and Congressmen in Washington for their consideration, urging them to oppose this proposed removal as a menace to the health and prosperity of the entire South."

This was adopted after some discussion.

By DR. DYER, voting thanks to the Medical Department of Tulane for the use of their building; to the newspapers for their excellent reports of the meeting; and to the retiring officers.

By DR. H. B. GESSNER, voting thanks to the Arrangement Committee. All of these were duly passed.

THE INSTALLATION OF OFFICERS THEN TOOK PLACE, the retiring president, DR. F. W. PARHAM, with a few apt remarks introducing DR. T. E. SCHUMPERT, the next president.

With a few words of thanks the doctor accepted for himself and other officers newly elected the burden and honors of office and then announced the following standing committees for the coming year:

Arrangements—Dr. Oscar Dowling, chairman, and the Shreveport members of the Society.

State Medicine and Legislation—Chas. McVea, R. C. Webb, Edmond Souchon, J. M. Barrier, P. E. Archinard, A. G. Friedrichs, C. J. Gremillion, R. M. Carruth, J. F. Piggott, George Friedrichs, C. H. Power, C. J. Williams, Isadore Dyer, George W. Lewis, E. M. Dupaquier, J. A. Storck, G. W. Remage, J. J. Archinard, E. W. Jones, J. Barnett, J. Steger, P. Michinard, H. S. Cocram, R. B. Paine.

Delegates to American Medical Association—P. L. Bellinger, Wm. Love, L. DePoorter, J. G. Martin, H. S. Joseph, N. M.

Hebert, F. Formento, G. F. Patton, M. J. Magruder, J. N. Roussel, G. C. Mouton, J. B. Elliott, E. S. Lewis, John Cochran, Paul Gelpi, W. A. Burleigh, Arthur Nolte, T. P. Singletary, H. Jones, T. T. Tarleton, J. F. Oechsner, W. M. Perkins, W. A. Holloway, Charles Carnier, Ed. D. Newell, E. A. Robin, A. Weber, W. L. Egan, William Scheppegrell, T. C. Foreman, E. H. Walet, R. G. Hawkins, Sidney Théard, Q. Kohnke.

Judiciary—E. L. McGehee, chairman; P. B. McCutchon, M. B. Tarlton, F. W. Parham, W. L. Dickson, A. F. Barrow, F. M. Thornhill, E. Souchon, G. M. Remage, J. M. Barrier, B. A. Little, R. M. Carruth, W. G. Owen.

Publication—H. B. Gessner, chairman; A. G. Friedrichs, H. S. Cocram.

Scientific Essays—T. S. Dabney, chairman; C. J. Landfried, D. J. LeBeuf, Ivan T. Siekman, E. O. Powers, G. Richard, M. H. McGuire, L. C. Cazenavette, W. A. Knolle, George A. B. Hays, L. G. Stirling, R. R. Grant, Gordon King, A. W. DeRoaldes, E. D. Martin, R. W. Seay, E. L. McGehee, J. F. Buquoi, J. R. Johnston, A. L. Metz, Hugh Kelly, Felix Larue, S. P. Delaup, W. G. Owen, C. Jeff Miller, J. D. Bloom, Alex. Robertson, Luther Sexton, John B. Elliott, Jr.; M. L. Hoffpauir, F. H. Carruth.

After which the meeting adjourned to meet in Shreveport in June, 1902.

The Banquet of the Society was given at the New St. Charles Hotel and some 150 local and country members of the Society and business men of New Orleans sat down to one of the most enjoyable feasts in the history of the body.

Aside from a good repast, the speeches were full of meat and purpose.

Dr. A. F. Barrow, of St. Francisville, made an affable toastmaster, and his bright wit provoked response in badinage from all points of the room. Not lacking in expected eloquence, he introduced in turn the following toasts which were duly and aptly responded to:

First—"The Louisiana State Medical Society and Its Future," T. E. Schumpert, president-elect, of Shreveport.

Second—"Our Presidents," Dr. F. W. Parham, retiring president Louisiana State Medical Society.

Third—"What We Owe to the Medical Profession," (Jack. Lafaïence) Mr. J. J. McLoughlin.

Fourth—"The Orleans Parish Medical Society in Community Development," Dr. E. D. Martin, president Orleans Parish Medical Society.

Fifth—"The Professional Man as a Citizen," Mr. J. Zach Spearing, New Orleans.

Sixth—"Medical Education as a Civilizer," Dr. F. J. Mayer, of Opelousas.

Seventh—"Future Prosperity of Louisiana," Hon. Jared Y. Sanders.

Eighth—"The Lay Press and Its Obligation to the Public in Medical Matters," Mr. A. W. Newlin, *Picayune.*

Ninth—"The Ladies," Dr. J. M. Barrier, vice-president-elect, Delhi.

The following members of the Society were in attendance at the several sessions, as indicated by the register:

Drs. F. W. Parham, New Orleans; Hermann B. Gessner, New Orleans; Jules Lazard, New Orleans; Henry Dickson Bruns, New Orleans; Otis M. Patterson, Bastrop; Rudolph Matas, New Orleans; Edmond Souchon, New Orleans; J. M. Barrier, Delhi; P. E. Archinard, New Orleans; H. L. Ducrocq, Lafourche Crossing; C. J. Grémillion, Alexandria; Andrew G. Friedrichs, New Orleans; O. Joachim, New Orleans; W. L. Dickson, Shreveport; Oscar Dowling, Shreveport; R. M. Carruth, Newroads; J. F. Pigott, Covington; Chas. McVea, Baton Rouge; I. M. Calloway, Shreveport; A. F. Barrow, St. Francisville; E. Thompson, Ville Platte; Geo. J. Friedrichs, New Orleans; C. H. Power, Rayne; C. J. Williams, Covington; Isadore Dyer, New Orleans; Geo. W. Lewis, New Orleans; E. M. Dupaquier, New Orleans; J. A. Storck, New Orleans; G. W. Remage, Jennings; John J. Archinard, New Orleans; Edw. W. Jones, New Orleans; J. Barnett, New Orleans; J. O. Steger, Mound; P. Michinard, New Orleans; H. S. Cocram, New Orleans; R. B. Paine, Mandeville; C. J. Landfried, New Orleans; L. G. LeBeuf, New Orleans; Ivan F. Siekmann, New Orleans; E. O. Powers, Grangeville; R. C. Webb, Rayne; G. Richard, Leonville; M. H. McGuire, New Orleans; L. L. Cazenavette, New Orleans; W. H. Knolle, New Orleans; Benjamin A. Littell, Opelousas; Geo. A. B. Hays, Jackson; B. H.

Guilbeau, Sunset; L. G. Stirling, Baton Rouge; T. S. Dabney, New Orleans; Gordon King, New Orleans; C. A. Gardiner, Bristol; A. W. DeRoaldes, New Orleans; E. Denègre Martin, New Orleans; R. W. Seay, New Orleans; E. L. McGehee, New Orleans; T. E. Schumpert, Shreveport; J. F. Buquoi, Pointe-à-la-Hache; J. R. Johnson, Buras; A. L. Metz, New Orleans; Hugh Kelly, New Orleans; Felix A. Larue, New Orleans; S. P. Delaup, New Orleans; W. G. Owen, Whitecastle; C. Jeff Miller, New Orleans; J. D. Bloom, New Orleans; A. R. Robertson, Pass Christian, Miss.; L. Sexton, New Orleans; John B. Elliott, Jr., New Orleans; M. L. Hoffpauir, Crowley; F. H. Carruth, Lobdell; R. R. Grant, Rosedale; T. T. Tarlton, Grand Coteau; John F. Oechsner, New Orleans; Wm. M. Perkins, New Orleans; W. A. Holloway, Plaquemine; F. M. Thornhill, Arcadia; Charles Chassaignac, New Orleans; Ed. D. Newell, St. Joseph; E. A. Robin, New Orleans; A. Weber, New Orleans; W. L. Egan, Shreveport; William Scheppegrell, New Orleans; T. C. Foreman, Foreman P. O.; E. H. Walet, New Orleans; C. H. Chavigny, New Orleans; Paul Gelpi, New Orleans; W. A. Burleigh, Fordoche; Arthur Nolte, New Orleans; R. G. Hawkins, Palmetto; T.P. Singletary, Baton Rouge; Sidney L. Théard, New Orleans; Hamilton P. Jones, New Orleans; Fred. J. Mayer, St. Landry; P. Bellenger, Tensas parish; Quitman Kohnke, New Orleans; M. M. Lowe, New Orleans; W. G. Branch, Bunkie; H. S. Joseph, Melville; W. E. Barker, Plaquemine; N. M. Hebert, Covington; J. P. O'Kelley, New Orleans; F. Formento, New Orleans; G. F. Patton, New Orleans; M. J. Magruder, New Orleans; J. N. Roussel, New Orleans; M. B. Tarleton, Jeanerette; G. Clinton Mouton, Rayne; Jno. B. Elliott, New Orleans; Edward Moss, New Orleans; E. S. Lewis, New Orleans; Jno. Callan, New Orleans; R. W. Walmsley, New Orleans; J. G. Martin, Lake Charles; P. B. McCutchon, New Orleans; G. D. Porter, Moreauville.

The Nominating Committee Appointed the Following Advisory Committee on the Consumptive Hospital with instruction to act in accordance with resolutions reported above:—Acadia—Dr. R. C. Webb; Ascension—Dr. J. D. Hanson; Assumption—Dr. T. B. Pugh; Avoyelles—Dr. C. J. Ducoté; Bienville—Dr. F. M. Thornhill; Bossier—Dr. B. Wise; Caddo—

Dr. J. C. Egan; Calcasieu—Dr. G. W. Remage; Claiborne—Dr. B. G. Wolf; De Soto—Dr. H. J. Parsons; East Baton Rouge—Dr. Chas. McVea; East Carroll—Dr. F. R. Bernard; East Feliciana—Dr. E. L. Irwin; Grant—Dr. T. J. Harrison; Iberia——Dr. G. F. Sabathier; Iberville—Dr. W. G. Owen; Jackson—Dr. A. E. Simonton; Jefferson—Dr. C. M. Brady; Lafourche—Dr. J. J. Ayo; Lafayette—Dr. J. D. Trahan; Livingston—Dr. J. B. Easterly; Lincoln—Dr. R. F. Harrell; Madison—Dr. J. O. Steger; Morehouse—Dr. O. M. Patterson; Natchitoches—Dr. J. S. Stephens; Orleans—Drs. T. S. Dabney, L. Sexton, L. G. Le Beuf, O. Joachim, Q. Kohnke, R. Matas, P. E. Archinard, G. F. Patton, H. B. Gessner, Felix Larue, F. W. Parham, H. S. Cocram, P. B. McCutchon, Arthur Nolte, Edmond Souchon, E. L. McGehee, Paul Archinard; Ouachita—Dr. J. Price; Plaquemines—Dr. J. R. Johnson; Point Coupée—Dr. L. M. Provosty; Rapides—Dr. C. J. Grémillion; Red River—Dr. C. E. Edgerton; Richland—Dr. J. M. Barrier; Sabine—Dr. H. L. Davis; St. Bernard—Dr. V. Schayot; St. Charles—Dr. V. Lehmann; St. Helena—Dr. C. M. Sitman; St. James—Dr. Numa Himel; St. John—Dr. J. P. Elmore; St. Landry—Dr. T. T. Tarlton; St. Martin—Dr. B. Guilbeau; St. Mary—Dr. B. W. Smith; St. Tammany—Dr. R. B. Paine; Tangipahoa—Dr. E. E. Stewart; Tensas—Dr. E. D. Newell; Terrebonne—Dr. C. M. Menville; Vermilion—Dr. M. R. Cushman; Vernon—Dr. J. E. Hope; West Baton Rouge—Dr. F. H. Carruth; West Feliciana—Dr. Jas. Kilbourne.

Medical News Items.

The Louisiana State Board of Health has appointed the following resident medical inspectors at Central American fruit ports: Dr. J. S. Allison, Belize, British Honduras; Dr. D. P. Albers, Livingston, Guatemala; Dr. P. R. Outlaw, Port Barrios, Guatemala; Dr. Percy Ahrons, La Ceiba, Spanish Honduras; Dr. King Holt, Bluefields, Nicaragua; Dr. Ed. B. Preis, Port Cortez, Spanish Honduras; Dr. Allen Jumel, Port Limon, Costa Rica; Dr. L. A. Wailes, Bocas del Toro, United States of Colombia.

Marine medical inspectors on fruit vessels were named as follows: Dr. R. D. Wilson, Limon route, Beverly; Dr. G. King Logan, Limon route, Anselm; Dr. J. E. Heidingsfelder, Honduras route, S. Oteri; Dr. George J. Tusson, Honduras route, Stillwater; Dr. K. W. O'Donnell, Bocas del Toro route, Kitty; Dr. H. J. Otto, Limon route, Holstein; Dr. W. B. Robertson, Limon route, Foxhall; Dr. W. G. Thigpen, Bluefields route, Alabama; Dr. T. S. Adams, Bluefields route, Hiram.

Louisiana State Board of Pharmacy.—Governor Heard has appointed the following members of the State Board of Pharmacy: Messrs. P. L. Viallon, E. N. Roth, Paul Fleming, M. Bernstein, Wm. M. Levy, Geo. T. Brown, F. C. Godbold, Max Samson and Walter T. Taylor.

The Birmingham Medical College held its annual commencement April 1, and graduated fifteen.

The Medical College of Alabama, Mobile, at the annual commencement, April 3, graduated thirty-seven in medicine and eleven in pharmacy. The faculty of the College includes: George A. Ketchum, M. D., dean; T. S. Scales, M. D.; Rhett Goode, M. D.; H. A. Moody, M. D.; Wm. B. Pape, secretary; Goronwy Owen, M. D.; Chas. A. Mohr, M. D.; W. H. Sanders, M. D.; E. D. Bondurant, M. D.

The New Orleans College of Dentistry announce a most interesting program for their Commencement Exercises, to be held at Tulane Hall, Monday, May 6. The success of this institution is to be commended and the faculty to be congratulated on the good showing in this its second year of work.

The American Congress of Tuberculosis will hold a joint session with the New York Medico-Legal Society at the Grand Central Palace, New York City, May 15 to 17. An elaborate program has been arranged and a profitable session is anticipated.

The American Laryngological Association will meet this year at New Haven, on May 27, 28 and 29. The gathering promises to be a good one, and the papers announced are all of

decided value to the specialist. Dr. A. W. DeRoaldes, of this city, has been some time a member of this body, and we are glad to notice that our friend Dr. Gordon King is among those to join the association this year, a deserved distinction.

The American Dermatological Association will meet this year in Chicago, at the Chicago Beach Hotel, May 30 and 31, and June 1, under the Presidency of Dr. Travers J. Shepherd, of Montreal.

The American Medical Association meets in St. Paul this year, and every effort is being made for a successful meeting. The dates announced are June 4, 5, 6 and 7.

There have been a number of prominent medical men in New Orleans recently—Dr. L. H. Warner, of New York; Dr. T. J. Corril, of the Willard (New York) Hospital for the Insane, and Dr. A. Botkin, of St. Petersburg, Russia.

The Shreveport Medical Society, on April 2, elected the following officers: Dr. T. E. Schumpert, president; Dr. W. L. Egan, vice president; Dr. F. J. Froter, recording secretary: Dr. J. J. Scott, treasurer; Dr. G. C. Chandler, corresponding secretary.

Dr. J. R. Kirkland, an old and respected practitioner of Meridian, Miss., died April 7. His nephew, Dr. C. L. Horton, is well-known in this city.

Dr. Ralph O. Marcour, U. S. N., a New Orleans physician, and who has been in charge of the United States Marine Hospital at Havana, Cuba, for the past two years, has returned to this city.

Dr. Geo. B. Lawrason, formerly of this city, but now assistant surgeon in the army and stationed in the Philippines, passed through the city recently.

The Medical Association of the State of Alabama met in Selma, April 16 to 19, and was well attended.

The Texas State Medical Association met this year in Galveston, April 23 to 27.

Some of the Parishes now allow the president of the local Board of Health a small salary. The office of president carries considerable work and correspondence, which entail, with other details of office, a degree of expenses and all parishes would do well to make a reasonable allowance for such purposes.

The Southwestern Tri-State Medical Society, of Texas, Oklahoma and Indian Territory will hold its next meeting at Dallas, October 1, 2 and 3, 1901. The Society promoters are anxious for a large gathering and the profession of Dallas are preparing to do everything possible to make the meeting a success. The officers of the Association active in organizing the next meeting are Drs. H. K. Leake and Saml. E. Milliken, both of Dallas.

The Tulane Medical Department announce their Commencement for Wednesday, May 1, 1901, beginning at 11:30 a. m., at the Grand Opera House, in New Orleans. The invitation issued is quite elaborate and contains a list of the Professors of the Faculty, together with the names of the orators of the occasion and the officers of the graduating class.

The Annual Address will be delivered by the Hon. Hannis Taylor, M. D., and the subject announced is "Relations of the Medical Profession to International Law."

The graduating class numbers about 125 in Medicine and 21 in Pharmacy.

The class officers are: President, James H. Foltz, of Arkansas; Vice-President, James H. Pridgen, of Texas; Secretary, Wm. E. Van Zandt, of Mississippi, and Treasurer, E. M. Hummel, of Louisiana.

Married: April seems to have been a favorite with the New Orleans profession—as evidenced by the following recent initiates into the order of Benedicts:

Dr. J. Birney Guthrie and Miss Sara Hall, married in Little Rock, April 9; Dr. William H. Robin and Miss Emma Meyer, married in New Orleans, April 17; Dr. J. N. Roussel and Miss Amelie Dugué, married in New Orleans, April 30.

Dr. E. A. Blount, formerly of New Orleans, now of Nacogdoches, Tex., was married April 23; the bride was Miss Minnie Lewis, daughter of Dr. Ernest S. Lewis, of New Orleans.

The JOURNAL is unwilling to discriminate in its distribution of good wishes and benedictions, so we express a hope that each of our confrères, burdened with new joys, may have a pathway strewn with roses of content and happiness.

THE CHARITY HOSPITAL BOARD OF ADMINISTRATORS have issued the report for 1900 of that institution. While much like former reports in general appearances, the dainty cover promises interesting contents.

Following the customary list of officers, visiting staff, etc., the vice-president, Dr. E. S. Lewis, relates the facts that during the year 8301 indoor patients were treated and 19,058 in the outdoor departments, with a total outdoor consultation of 74,995. There were 1464 ambulance calls.

The current expenses amounted to $117,002.11; revenues, $119,556.30.

THE PHILADELPHIA COUNTY MEDICAL SOCIETY now issues its monthly proceedings in a neatly bound volume.

HAVANA REPORTS show a death rate for March of 26.28 per thousand; the lowest previous death rate for eleven years being 27.60 in 1893. There were but four cases of yellow fever with but one death. It is interesting to note the commentary of Major Gorgas, chief sanitary officer, in this regard: "Our present freedom from fever is in part due to the systematic and extensive way in which we have been killing the mosquitoes for the last month."

No small-pox has occurred since August, 1900.

DR. J. R. FRIDGE, formerly of Gonzales, now of Baton Rouge, advises the JOURNAL and his friends of his serious injury in November last, sustaining a Pott's fracture of his left leg, which has compelled the use of crutches ever since. The doctor projects a trip to New York, where he hopes to recover from the effects of his injury.

THE AMERICAN ACADEMY OF MEDICINE will hold its Twenty-sixth Annual Meeting at the hotel Aberdeen, St. Paul, Minn., on Saturday, June 1, 1901, at 11 A. M., continuing through Monday, June 3.

The principal features of the meeting will be a symposium on "Institutionalism," and another on "Reciprocity in Medical Licensure." Series of valuable papers on both topics have been promised, as well as interesting papers on some other subjects.

The Detroit Medical Journal is a new candidate in the field of medical letters.

The Tennessee State Medical Society, at the sixty-eighth annual meeting, in April, elected the following officers: Deering J. Roberts, M. D., Nashville, President; J. B. Murfree, Jr., M. D., Murfreesboro, L. A. Yarbrough, M. D., Covington, W. B. St. John, M. D., Bristol, vice presidents; A. B. Cooke, M. D., Nashville, secretary; W. C. Bilbro, M. D., Murfreesboro, treasurer.

Next place of meeting: Memphis, Tenn., on the second Tuesday in April, 1902.

The St. Paul Meeting and Yellowstone Park.—Arrangements have been completed for an excursion of the members of the American Medical Association to Yellowstone Park. The Committee of Arrangements has finally succeeded in persuading the officials to open up the park a week earlier than usual in order to accommodate the association. A special train will be run from St. Paul to the Yellowstone Park and the railroad officials have promised to do everything in their power to make it satisfactory to all concerned. The rates will be very low, but how low can not at this time be definitely stated.

Jefferson Medical College Graduates of the Year 1891 are invited to hold a class reunion in Philadelphia. The president of that class desires all interested to respond as soon as possible upon these points:

1. Do you think it probable that you will attend? 2. What time between June 15 and September 1 would suit you best? 3. Would you prefer meeting in Philadelphia or Buffalo?

Address Dr. Matthew M. Smith, 101 West Sixth street, Austin, Texas.

Association of American Medical Colleges will hold its next regular meeting at the Hotel Ryan, St. Paul, Minn., Monday, June 3, 1901. It will consist of two sessions—an educational

session and a business session. To the educational session all persons interested in medical education are respectfully invited. The representatives and associates of the Association of Southern Medical Colleges have received a special invitation. The members of the Confederation of State Examining and Licensing Boards are also invited. There will also be an exhibition of work done in medical colleges.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

The Treatment of Fractures. By W. L. ESTES, A. M., M. D. International Journal of Surgery Co., New York, 1900.

This is an excellent treatise on fractures, brief, but to the point, and abounding in sensible advice. We can cordially commend it to those who are not seeking one of the more voluminous works on fractures. It is eminently practical. PARHAM.

Manual of Surgical Treatment. By CHEYNE & BURGHARD. Lea Bros. & Co., Philadelphia and New York, 1901. Vol. IV., 1901.

We have previously noticed the other volumes, already published. As we remarked before, this work, while not seriously neglecting pathology, has in view particularly the treatment of surgical diseases and injuries. Volume IV treats of the surgical affections, the joints (including excisions) and the spine. The standard set is well maintained in this.

PARHAM.

American Text-Book of Physiology. Edited by WM. H. HOWELL, PH. D., M. D. Vol. II. W. B. Saunders & Co., Philadelphia and London, 1901.

The subjects comprised in this volume are: Muscle and Nerves, Central Nervous System, Special Senses, Special Muscular Mechanisms and Re-

production. Even the busy man in practice finds the hour for physiology, and with the broader experience of his practice he brings a clearer intelligence into his reading, Physiology each day grows more experimental in the way its teachers present it, and this makes new theories, which must interest the men who as physicians are so close to the explanation of the vital ultimate.

No pains have been spared in making each section of the American Text-Book of Physiology complete, and what we have said of volume one, needs only to be built upon with fresh and laudatory commentary. Among the improvements in the second edition is to be noted revision in the chapter on the Central Nervous System, which has been in large part rewritten. The second volume has some 600 pages fully illustrated, and is as complete in detail as a willing publisher and able editor can make it.

DYER.

A Text-Book of the Practice of Medicine, by JAMES M. ANDERS, M. D., Ph. D., LL. D. Illustrated. Fourth Edition, thoroughly revised. W. B. Saunders & Co., Philadelphia and London, 1900.

This fourth edition presents a re-arrangement of the text, a re-writing of many articles and some additions. It is a practical work which compares most favorably with others of recent date on the same subject. It is more complete in some respects. On the latest developments it gives a few more words of information, as for instance, on intoxications and on diseases due to animal parasites. In other words, the book is up-to-date in all respects and suits the needs of both the student and the practitioner of to-day.

DUPAQUIER.

Introduction to the Study of Medicine, by G. H. ROGER, Professor Extraordinary in the Faculty of Medicine of Paris, authorized translation by M. S. GABRIEL, M. D., with additions by the author. D. Appleton and Co., New York, 1901.

Not a few of us would be pleased to be only twenty years old just now, entering upon the laborious study of the medical sciences when we consider the great advantages offered to the student at the present time in the journey to the goal. Trained teaching as offered by a book like this, indeed, throws a flood of light ahead and studies are steered clear of obstacles.

There are facts in this book, nothing else; no space is wasted. But the field is broad enough to allow all of us, the most experienced included, to step in and find refreshing food, at all times This book is simply a classic of the latest type and is, therefore, heartily recommended for its great usefulness and practical value.

DUPAQUIER.

International Clinics, Vol. IV, Tenth Series. J. B. Lippincott Co., Philadelphia, 1901.

The clinical lectures and articles in this, as in the preceding volumes, are all valuable. Among the most attractive we note, the curious "*History*

of the United States Pharmacopeia," up to the present time, the opening of the twentieth century, with the cheering news that the U. S. P. Convention is now a *legal body*, so that our own U. S. P.'s authority is now firmly established. Other articles deal with these subjects: Mosquitoes and the Prophylaxis of Malaria; On the Use of the Fixed Catheters in the Treatment of Urinary Infection and of Prostatic and Urethral Hemorrhage; Recent Advance in Diagnosis; The Rôle of the Blastomycetes or Ferments in the Etiology of Cancer, with a good plate on the frontespiece showing the Blastomycetes; The Etiology and Morbid Anatomy of Various Diseases. The last article is practical and useful and is a good compendium for ready reference. The International Clinics are worth having.

DUPAQUIER.

A Compendium of Human Physiology. Especially adapted for Medical Students. By ALBERT P. BRUBAKER, A. M. M. D. Tenth edition, revised and enlarged. P. Blakiston's Son & Co., Philadelphia, 1900.

Ten editions should be sufficient evidence of merit in a work of such usefulness to the student as the compendium before us. No intention of making a textbook of this handy volume is aimed at, but just what it pretends to be, a compendium for reviewing the subject it discusses. The author has revised and enlarged the present edition to meet the advances in methods of study in physiology. The absence of illustrations, except in a few chapters, might be open to criticism. DYER.

The International Medical Annual. A Year Book of Treatment and Practitioner's Index. E. B. Treat & Co. New York and Chicago, 1901.

For nineteen years the publishers of this handy book of reference have found the endorsement of the reading medical profession. Like other works of its kind, the purpose is directed at providing a succinct review of new methods and treatment in practice which have been suggested in all countries during the year past. In great part this is accomplished in the Year Book, which in an alphabetic arrangement presents all subjects thought worthy of abstract by the several collaborators, selected among the leading men of the profession in this and other countries. While much of importance may have been missed in the selection of interesting and instructive matter, the work must always appeal to the general practitioner as a labor saving and convenient means of getting information on current topics. DYER.

Progressive Medicine. Vol. I, 1901, March. Edited by HOBART AMORY HARE, M. D., assisted by H. R. M. LANDIS, M. D. Lea Bros & Co., Philadelphia and New York, 1901.

The demand for the digest of current medicine and surgery is almost necessary because of the vast amount of work accumulating as the days go by. This demand was anticipated in the establishment of the work before us, and the field of its usefulness every day grows. No pains are spared

by the publishers in selecting the best men for the articles presented, and their work is evidence of the care employed. It is always difficult in small space to indicate much of the detail of any work of cyclopedic character, but in mentioning that the subjects in the present volume cover the following branches, we feel that the reader must be interested: Surgery of the Head, Neck and Chest, a review by Dr. DaCosta of recent procedures advanced and applied to these regions, with free illustration where indicated; Infectious Diseases, including Acute Rheumatism, Croupous Pneumonia and Influenza, containing about one hundred pages of running criticism and discussion of the recent literature and treatment of the diseases instanced; Diseases of Children, being a systematic presentation of the prevailing diseases of children, with suggestions for feeding, for treatment and prevention, by Dr. Floyd Crandall, long time authority on this branch. The chapter on Pathology is written by Dr. Hektoen, of Chicago, and is characterized by a thorough respect for detail in reference and review. The concluding chapters are devoted to the special branches of laryngology, rhinology and otology. DYER.

Tuberculosis as a Disease of the Masses and How to Combat It. Prize Essay, by S. A. KNOPF, M. D. Awarded prize by International Congress to Combat Tuberculosis, Berlin, 1900. M. Firestack, publisher, New York, 1901.

The author has presented an excellent analysis of the disease and its dangers to the individual and to the community; his logical conclusions lead to the methods of combating the disease. This question he takes up with completeness of detail, submitting each phase with care and preciseness. The home life, surroundings, diet, clothing, etc. are discussed and some attention is given to therapeusis medicinally and through sera. For the most part, argument is directed at the hygienic and climatic care of the disease and its victims. Systems of sanitary rules are submitted; diagrams and schemes for out door treatment at home and at sanitaria are indicated and illustrated. The practical analysis, the free illustration and the ethic character of the brochure must commend it to the attention of those interested. DYER.

Self Examination for Medical Students. Third edition enlarged. P. Blakiston's Son & Co., Philadelphia, 1901.

This handy volume with 3500 questions on all branches of medical subjects will prove an excellent and convenient *vade mecum* for the medical student who wishes to review for examinations. It is comprehensive and pertinent.

Obstetric Clinics. By DENSLOW LEWIS, PH. C., M. D. E. H. Colegrove, Chicago, 1900.

This work consists of a series of clinic lectures on practical obstetrics and gynecology, together with remarks on criminal abortion, infanticide

illegitimacy, the restriction of venereal diseases, and the regulation of prostitution and other medico-sociologic subjects.

As one would infer from the varied subjects, there is no attempt at an orderly and systematic arrangement of a text-book, but rather a general review of such matters and the addition of operative technic, which makes the work of interest to the general practitioner rather than to students. The varieties of infection as observed in the pregnant, parturient and puerperal woman are dealt with at length, especially the diagnosis and and treatment. The restriction and regulation of prostitution are discussed in a manner denoting some well defined ideas, although not crystallized into definite propositions applicable to all requirements of society. The lecture on the relationship of syphilis to pregnancy, the puerperal state and the new-born infant is quite exhaustive and instructive.

The work is written in a style that seldom fails to attract, and will no doubt be read by many who wish to review obstetric matters but dislike text-book reading. MILLER.

Eye, Ear, Nose and Throat, a Manual for Students and Practitioners. By WILLIAM LINCOLN BALLENGER, M. D., and A. G. WIPPERN, M. D., Chicago.

This manual is one of the series of pocket text-books published by Lea Bros. & Co., and is an 8 vo. edition containing 511 pages of reading matter, illustrated with 150 engravings and six colored plates. The section devoted to the eye is written by Dr. Wippern, and the ear, nose and throat by Dr. Ballenger. These authors have, by careful review of the recent literature on these special branches and an elaborate compilation of practical facts gained in their own valuable experience, brought out a most useful little volume to serve as an aid to the student and a reliable reference for the general practitioner. The text is well arranged, brief and to the point. DEROALDES AND KING.

PUBLICATIONS RECEIVED.

Transactions of the American Dermatological Association, 1900.

Hernia, by Samuel H. Linn, M. D.

Ephemeris, edited by E. H. Squibb, M. D., 1901.

A System of Practical Therapeutics, edited by Hobart Amory Hare, M. D., Vol. II. Lea Bros. & Co., Philadelphia and New York, 1901.

A Compend of Human Physiology, by Albert P. Brubaker, M. D. P. Blakiston's Son & Co., Philadelphia, 1900.

Introduction to the Differential Diagnosis of the Separate Forms of Gallstone Disease, by Professor Hans Kehr. Translated by

William Wotkyns Seymour, M. D. P. Blakiston's Son & Co., 1901.

The International Medical Annual, 1901. E. B. Treat & Co., Chicago and New York.

A Text-Book of Gynecology, edited by Charles A. L. Reed, M. D. D. Appleton & Co., New York, 1901.

The Medical News Pocket Formulary for 1901, by E. Quin Thornton, M. D. Lea Bros. & Co., Philadelphia and New York, 1901.

Laryngeal Phthisis, by Richard Lake, F. R. C. S. P. Blakiston's Son & Co., Philadelphia, 1901.

Memoranda of Poisons, by Thomas Hawkes Tanner, M. D., and Henry Leffman, M. D. P. Blakiston's Son & Co., Philadelphia, 1901.

Self-Examinations for Medical Students. P. Blakiston's Son & Co., Philadelphia, 1901.

Fifteenth Report of the Lunacy Commission, December, 1900.

Handbook of Materia Medica, Pharmacy and Therapeutics, by Samuel D. L. Potter, M. D. P. Blakiston's Son & Co., Philadelphia, 1901.

International Clinics, edited by Henry W. Cattell, M. D. J. B. Lippincott & Co., Philadelphia, 1901.

The Feeding of Infants, by Joseph E. Winters, M. D. E. P. Dutton & Co., New York, 1901.

Lectures on Nasal Obstruction, by W. A. Marmaduke Shield, F. R. C. S. P. Blakiston's Son & Co., Philadelphia, 1901.

The Relative Susceptibility of the Domestic Animals to the Contagia of Human and Bovine Tuberculosis, by R. R. Dinwiddie.

The Stock Poisoning Plants of Montana, by V. K. Chestnut and E. V. Wilcox.

REPRINTS.

Remarks on the Surgery of the Nineteenth Century, by Hal C. Wyman, M. D.

The Medical Treatment During the Adolescent Period, by Edwin Rosenthal, M. D.

Fatty Degeneration of the Heart, by Thomas E. Satterthwaite, M. D.

A Review of the History of Cardiac Pathology, with Especial Reference to Modern Conceptions of Myocardial Disease—Aneurism of the Arch of the Aorta, with Rupture into the Superior Cava—Some Notes on the Treatment of Rheumatism—Progressive Pernicious Anemia, by Alfred Stengel, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR MARCH, 1901.

CAUSE.	White.	Colored.	Total.
Fever, Malarial (unclassified)	....	....	....
" " Intermittent	....	2	2
" " Remittent	....	....	....
" " Congestive	....	....	....
" " Typho	....	....	....
" Yellow	....	....	....
" Typhoid or Enteric	6	2	8
" Puerperal	....	....	....
Bronchitis	7	8	15
Diphtheria	1	1	2
Influenza	6	6	12
Measles	....	....	....
Whooping Cough	1	....	1
Pneumonia	30	29	59
Cancer	12	7	19
Tuberculosis	51	47	98
Diarrhea (Enteritis)	3	5	8
Dysentery	4	1	5
Hepatic Cirrhosis	8	1	9
Other Diseases of the Liver	4	1	5
Peritonitis	5	....	5
Debility, General	....	....	....
" Senile	12	7	19
" Congenital, Icterus	6	2	8
Bright's Disease (Nephritis)	27	19	46
Uremia	....	....	....
Heart, Diseases of	33	22	55
Apoplexy	15	6	21
Meningitis	2	3	5
Tetanus, Idiopathic	....	....	....
" Traumatic	....	....	....
Trismus Nascentium	4	2	6
Injuries	17	7	24
Suicide	1	....	1
All Other Causes	72	35	107
TOTAL	327	213	540

Still-born Children—White, 18; colored, 10; total, 28.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 18.68; colored, 28.40; total, 21.60.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure	30.01
Mean temperature	61.3
Total precipitation, inches	4.26

Prevailing direction of wind, south.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

VOL. LIII. JUNE, 1901. No. 12.

Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of fifty reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.]

STRYCHNIN—ITS CLINICAL USES.*

BY J. M. BARRIER, M. D., DELHI, LA.

At the solicitation of the chairman of the section of Materia Medica and Therapeutics, I have consented to present to this society a paper on the clinical uses of strychnin. I have not endeavored to exhaust the subject, but have confined myself chiefly to my own experience in the therapeutics of this drug.

Strychnin is one of the most valuable remedies in the armamentarium of the physician. It is, considering the many indications for its use, a comparatively new remedy. Within the memory of many of the older members of this society, its use was confined almost exclusively as an ingredient in the various condition powders and as a means of putting a perpetual quietus to a few disreputable members of the canine species. In his reminiscences of the drug business, an old pharmacist to a reporter of *New York Times* says: "Forty years ago an ounce of strychnin would last a druggist ten years, and now a druggist will use an ounce a month." No drug in the pharmacopeia is prescribed for a greater variety of diseases, or whose field of usefulness is greater than strychnin.

*Read before the Louisiana State Medical Society April, 1901.

If we consider a moment the physiologic action of strychnin, we readily see how varied are the indications for its use. There is scarcely an organ in the human body that is not affected directly or indirectly by it. By its tonic effect on the mucous membrane of the stomach, it stimulates the secretions, improves the digestion, increases the appetite and exalts the vital powers. As a heart stimulant it is the equal of digitalis without its evil or uncertain effects, and at the same time a respiratory stimulant. It is a nerve tonic and a stimulant to the vaso-motor centers.

I will first mention its use in the treatment of pneumonia. In my experience strychnin has proved the most useful drug in the treatment of this disease. I say this advisedly, for the other drugs prescribed and which are valuable there could be a substitute, but at present I do not believe there could be a substitute for strychnin that would fulfill the indications equally as well. The mortality of pneumonia has been greatly lessened in the last decade by discarding the scalpel, veratrum and aconite, the antipyretics and blisters, and the various nauseating expectorants, and the substitution of a more rational and humane treatment. Statistics of many hospitals may not prove this assertion, for, as a rule, it is the impoverished in body and purse who seek admission, and no treatment can be given a fair test with such patients and under such circumstances.

Pathologically considered pneumonia is a disease of the lungs, but from clinical experience we know the chief danger is from weakness of the heart. In the management of this disease our chief concern should be to maintain the full regular and tonic action of that organ as nearly within the physiological limits as possible. Forty years ago alcohol was the physician's main reliance to meet this indication. He thought he could no more treat pneumonia without whisky than he could run a steamboat without water. There is now no doubt but that as many patients died from alcohol coma as from the disease itself. Twenty years ago when I was a medical student, my professor on practice greatly condemed veratrum and aconite in pneumonia, but digitalis was his specific. Had his treatment been followed by his students the last census would doubtless have been in the sixties instead of the seventies.

To meet this indication, the weakness of the heart, the administration of strychnin at the onset of the disease is neces-

sary. I lay particular emphasis on this point—commence with strychnin at once. However, it is too frequent that we are not called until the second stage is far advanced, when there are symptoms of impending heart failure. In these cases, also, strychnin is our chief reliance for prompt and certain results.

My mode of administration is as follows: As soon as a diagnosis is made, commence with strychnin, $\frac{1}{30}$ to $\frac{1}{16}$ grain every 4 to 6 hours and continue throughout the disease, watching carefully its effects and not pushing it beyond its physiologic limits. The cumulative effects of this drug are not as often produced as most of our text-books ascribe.

I will report two cases which have recently occurred in my practice:

CASE I.—Colored, 4 years old. Had had pneumonia one week, no medical attention; pulse and respiration unable to count; cough short and frequent; bronchial secretions checked; tongue dry and parched; bathed in a cold, clammy perspiration, and almost in articulo mortis. Gave $\frac{1}{60}$ gr. strychnin hypodermically; ordered 2 gr. each calomel and ipecac in 8 powders to be given one every half hour, and $\frac{1}{60}$ gr. strychnin every four hours. Next morning, to my surprise, my patient was better. Continued the strychnin and ordered quinin every four hours and turpentine every four hours. No expectorants. Patient made a rapid recovery.

CASE NO. 2.—White, male, aged 19 years. Several previous attacks. Several days' duration; right side completely consolidated; temperature 105 deg.; respiration 35; pulse 125; sputum streaked with blood; cough incessant, rasping, dry and painful; pain over affected side. Treatment much as in above, my main reliance being strychnin. In this case I occasionally combined digitalis with the strychnin; also gave carbonate of ammonia, and occasionally gave heroin to relieve painful cough. Resolution was delayed and convalescence was slow, but patient finally pulled through. In lauding strychnin in the treatment of pneumonia I have not come to believe it is a specific, nor do I wish to underestimate other valuable measures and remedies. In pneumonia, as in many other diseases, there can be no routine treatment laid down, and it is the wise physician who treats his patient as well as the disease.

In the treatment of La Grippe strychnin is also a valuable remedy. This disease produces a relaxation and depression throughout the nervous system out of proportion to the symptoms as manifested at any time. By the administration of strychnin at the beginning we stimulate the nervous system, especially the vaso-motor centers, and enforce the entire system to better resist the ravages of this insidious disease. In the debilitated condition and nervous prostration that so frequently follow grippe, I have found strychnin, combined with one of the mineral acids and a bitter tonic, to be one of the best prescriptions. In the various bronchial troubles where there are debility and loss of appetite strychnin is useful. In tuberculosis, while we do not expect to cure, our object is to prolong life and make our patient as comfortable as possible. We have in strychnin a most valuable tonic.

Strychnin has long held an important place in the therapy of malaria. It is not a specific in the sense that quinin is. In the treatment of the quotidian, tertian, and quartan forms of malaria it possesses no value. But in the intervals to prevent the septenary periods it is a valuable agent. I have tried various tonics to find a specific chill cure, but the old prescription, quinin, strychnin, iron and arsenic comes nearer a guarantee than any combination I have ever used. Few cases of chills can resist a thirty days' treatment on this prescription. In the so-called typho-malarial, continued, or slow fevers, I have derived splendid results from its use. Even here it is not antagonistic to the malarial poison; it is by its action on the nerve centers, heart and circulatory system.

In malarial hematuria, strychnin is one of the most valued drugs. Without entering into the pathology of this disease, I will employ the following simile which pictures very clearly the pathologic condition. It is cyclonic in character, comes on suddenly, the whole superstructure has been disturbed, broken fragments and debris are all around. The entire human organism has been disturbed; the stomach deranged, liver engorged, kidneys congested, nervous system shocked, the heart weakened and the whole circulatory system impaired. The time for quinin or to prevent the cyclone is past—the damage has been done. The rational course to pursue is to remove the debris, reconstruct and repair the damaged parts. As the reconstructive strychnin

is the remedy. While elimination is being accomplished by the alkaline cathartics, strychnin reconstructs and repairs by its tonic action on the nervous system, heart and circulation. Strychnin should be given here to its full physiologic limit.

In the algid and comatose forms of malaria, strychnin is especially beneficial. In the alluvial lands of Louisiana and Mississippi these are very prevalent. "Doctor, come quick; the baby is having spasms" is a call the country doctor has heard more than once. It is an hour of extremity that calls for quick action and presence of mind. The agony and writhing of that little one and the piteous cry of the mother, "Oh, Doctor, save my child!" is a scene that will ever remain in memory. Control the convulsion, external stimulation and strychnin hypodermically. I have given as much as 1-120 of a grain to a child 6 months old, and then 1-120 grain every two hours until reaction was established. If the action of the heart can be sustained and the respiration kept going until the toxemia is relieved, our little patient has a chance. But how often do they succumb before we are able to do anything for their relief.

In the functional troubles of the stomach strychnin stands almost first among drugs. Dyspepsia and indigestion have yielded to strychnin in my hands more often than to any other drug. Strychnin with one of the mineral acids is a favorite prescription in functional dyspepsia. It corrects the nervous prostration and acts as a nerve tonic, and as a bitter tonic stimulates the secretions, increases the appetite and improves the nutrition.

In constipation, strychnin heads the list among drugs. Theoretically, by its peristaltic action on the intestines, it is indicated. But my success in these troubles has been far from brilliant, and had my practice been confined to this I would long since have retired from the profession. We are, however, called to treat these cases, and we can often give relief with drugs, placing emphasis on diet, habit, etc. Strychnin in combination with the various laxatives is our surest remedy.

In dilatation of the stomach strychnin is indicated. I treated one case very successfully with strychnin. I made the diagnosis of dilatation. Of course, that did not make it so, but as I could get no one smarter than myself to confirm or disprove the diagnosis, I called it dilatation. Had treated the case for

nearly everything else, and with various and divers prescriptions, to no effect. I commenced with strychnin, $\frac{1}{16}$ gr., and continued for two months, holding up occasionally, lest toxic symptoms be produced. Patient was entirely relieved, and has remained so ever since.

In intestinal catarrh and indigestion, strychnin is indicated. The benefit is to be derived from its tonic effect on the nervous system rather than any direct action on the intestinal mucous membrane. The most successful treatment in these cases is aseptic and antiseptic and proper regulation of diet.

It is as a heart stimulant and tonic that strychnin takes preeminently first place. The superiority it has over digitalis and other heart tonics is demonstrated by the fact that there is no cumulative depressant second or third stage. That it may be pushed for a longer time and give satisfactory and definite results places it at the head of heart tonics. In surgical shock it is our most trusted and reliable remedy. In the enfeebled heart from chloroform narcosis it is the most potent and prompt remedy. The administration of strychnin before an anesthetic is a wise precaution, and has become a routine practice with many surgeons. In any long continued disease resulting in enfeeblement of the heart, strychnin is a valuable drug.

In the various neuroses strychnin is indicated and is largely prescribed in these affections. In the treatment of gastralgia I have had gratifying results. A case in point was the writer himself. In 1895, after an attack of malarial hematuria, commencing during convalescence and continuing about eighteen months, I was troubled periodically with the most intense gastralgia. The least thing eaten was liable to bring on an attack. A fast was liable to produce the same. It was the veritable biblical "thief"—liable to come at any hour when least awares. Imagine 200 pounds doubled up into about the size of a cigar box. Morphia hypodermically would give immediate relief, but the horrors of being a morphin fiend were constantly before me. After using many things and consulting several physicians to no avail, I commenced with strychnin, $\frac{1}{16}$ gr. three times a day and continued more than two months with intervals of intermission. The last attack was in March, 1897, since which time I have been able to eat anything from the luscious bivalve to Welsh rare bit.

Strychnin is highly regarded and one of the most frequently preserved remedies in the various paralyses. My experience in these affections is rather limited. I prefer to do as a fellow-student when asked by the Professor what he would do in so-and-so, answered that "he would send for a doctor." So I usually send these cases to a doctor. However, there are several ailments of this class for which I have prescribed strychnin with splendid results, *e. g.*, in atony of the bladder in women.

Strychnin is a stimulant to the genito-urinary organs, it is therefore indicated in impotence. There are a class of patients, especially among the negroes, who come to the doctor with this little tale of woe: "They has lost all feeling for a woman, or vice versa, they has lost feelin' for a man." With that race life is not worth living in that condition. You feel like you ought to give them a severe object lesson in morals, but as you are not teaching morals *exclusively*, just advise moderation and temperance; give your patient a box of strychnin tablets and the next time you see him he is all smiles and you know youth has been again renewed.

In chronic alcoholism strychnin is a valuable remedy. Nearly all the so-called cures contain strychnin. My experience in this class of cases is also limited, as I live in a strictly dry community. I leave this to be discussed by others living in less civilized communities.

There are other indications for the use of this valuable drug, and I trust others may be provoked to give their experience.

I have not attempted to present anything new and original, my object being to emphasize the importance of this drug as a therapeutic agent.

THE ANNUAL REPORT OF 1901, WITH AN HISTORICAL SUMMARY OF EDUCATIONAL PROGRESS, TO THE PRESIDENT OF THE TULANE UNIVERSITY OF LOUISIANA, AT THE ANNUAL COMMENCEMENT OF THE MEDICAL DEPARTMENT, MAY 1, 1901.

BY PROF. STANFORD E. CHAILLÉ, M. D., DEAN, NEW ORLEANS.

MR. PRESIDENT—A large portion of the students attending the Medical Department are the sons, relatives or friends of its alumni, hence, the greater the number of these, the more they

contribute to the welfare of our college. This day closes the sixty-seventh year's existence of our college and our graduates will number 3515 in medicine and 326 in pharmacy. All of these 3841 graduates, except 768, have been graduated during my own official service, which began in 1858.

My last annual report called attention to the facts that attendance on four, instead of three, annual sessions was now required of all students who began their first course in a medical college after January 1, 1899, and that, as a result of the greater time and expense thus imposed to complete a collegiate medical education, the number of students would decrease, and, therefore, that there would be fewer students in attendance at the present than at the preceding session. The last session was attended by 426 students, the greatest number in the history of our college and 414 have attended the present session, a loss of only 12. That the loss was no greater was due to the increased prosperity of our section of country. But our actual loss was more serious than the above figure indicates, because this, as every other medical college, has, attending every session, a considerable number both of students and of graduates who, having completed all the sessions required, pay nothing, except an insignificant registration fee. And the number of these non-paying students is so much greater than at the preceding session, that our financial receipts have decreased to a much greater extent than is indicated by the deficiency in the number of our students.

At the present session there have been a great number of students attending the last session of their three-year course. This will leave us, at the next session, with few students except those of the first, second and third years of the four-year course. The number of every one of these classes will be less than were the classes of the three-year course and there will be no full graduating class at the next session. The results will be that the number of students attending our next will be less than at the present session, and that the number of our graduating class and the financial receipts will be much less. These results will surely ensue unless unusual prosperity should unexpectedly conteract them.

Our decreasing classes will not begin to increase until the session after the next (1902–3), when there will be, for the first

time, four full classes attending the required four-year course. How many years it may take to regain the maximum number who ever attended, will depend chiefly on the financial prosperity of our section and on the sanitary welfare of our city.

The chief value of history is to enable us better to comprehend the present and to foresee the future. In 1893, our students numbered 420; then the three instead of the four-year course was required; thereafter the number decreased to as few, in 1895, as 340, and it was not until the seventh year that our annual losses were fully regained by the attendance of 426 students in 1900. The six intervening years (1893–99) were unfavorable, in that "hard-times" prevailed; there was war one year and, worse still, there were for three years quarantines against yellow fever. If the coming years have no such evils in store, the maximum number of students who ever attended, now on the decline and without reasonable hope of increase until 1902–3, will probably be regained in less than seven years.

During the first fifty-nine years' existence of this college, attendance on only two annual sessions was required of graduates; during the next six years, three, and during the last two years four annual sessions have been demanded. These rapidly increasing requirements have added greatly to the burdens imposed on medical teachers and students. What compensating benefits will result? The chief benefit will be to the public, supplying it with medical practitioners possessing far greater knowledge and skill. Further, the power and influence of the medical profession will be greatly promoted.

The medical profession of the United States, as a whole, has never had at home the public influence it should have, nor has it ever been much respected abroad; because all other civilized countries have required a much higher standard of education preparatory to the study of medicine, and also because the least time required in any such country for graduation in a medical college has been four annual sessions of eight or nine months, and in the colleges of some countries six, eight, and even ten years of study are demanded. Besides the gain of greater respect and influence both abroad and at home, the medical profession will derive further advantage by the reduction of the enormous disproportion of medical men to the population, there being in the United States two, three and even four times more medical prac-

titioners, relative to the total population, than in the various other civilized countries. Hence, however, vexatious and harrassing to medical teachers and students may be the increasing requirements to complete a medical education, the results will surely be beneficial to both the medical profession and the public.

Graduates of 1901.—The highest authority teaches, "by their fruits ye shall know them." You are this year's fruits of the Medical Department, and its repute and welfare greatly depend on you and your predecessors. If you gain professional reputation your college will thereby gain both additional repute and an increase in the number of its students; and if any graduate should ever become a discredit to the medical profession, the shadow of this discredit will be reflected on your college. Hence, though you leave us this day, our interest in your careers will follow wherever you may go. You will leave behind you an earnest desire to promote your future success and an interest in you so strong that there will be joy or grief as you may succeed or fail. While thus bound to you, what ties should bind you to your college?

The more it may increase in fame and influence the greater the repute reflected on every one of you and the greater the help that can be given whenever you become solicitors, as many hundreds of your predecessors have been, for such testimonials and influence as may secure profitable and honorable professional positions. Thus, as self-interest binds your college to you, so your self-interest binds you to your college. Further, your teachers have been for years laboring for your welfare, and, although this was their duty, yet, if well and lovingly done, some gratitude is due, and this, with the memory of the friendships formed and of the pleasures enjoyed here during the days of your youth, should prove stronger even than self-interest to stamp on your hearts appreciation of the time-honored designation of every graduate's college as his dear mother or alma mater. In truth, the mutual interest and affection that bind mother and son should bind college and graduate.

Every one of you can serve your college in at least three ways; you can gain professional reputation—by conforming your conduct to the Code of Ethics, a copy of which accompanies the diploma of every one of you—by properly applying the

knowledge you have here gained and by striving daily to increase this knowledge. You can cultivate the power and grace of speech and the still greater potency of the pen, and use these acquirements not only to increase your own reputation, but also to maintain and strengthen your college. And you can use your influence to contribute to the number of our students and thereby to the welfare of the college that gave you professional birth.

Finally, your Faculty cordially welcomes you to the ranks of your chosen professions and ardently hopes that your careers may contribute to the fame of your professions and of your college, to the relief of all who may seek your aid, and, in such wise, to your own prosperity and happiness.

HISTORICAL SUMMARY OF EDUCATIONAL PROGRESS, 1834–1901.

This, the first year of the Twentieth Century, is the fiftieth year since I became a medical student in this college. These facts, together with the absence from this day's program of one of our usual speakers on Commencement Day, have been my chief temptations briefly to review the progress of education in our college, especially during the last half-century.

In order that our progress may be better appreciated, it is necessary to understand why medical education in our country was so long comparatively so defective; and why there has been, especially during the past ten years, such notable progress in correcting previous defects.

During many years of our country's history the great majority of its physicians had no better medical education than that gained as pupils in a doctor's office, and our medical colleges originated as substitutes for this very inadequate apprentice system. Our colleges were neither founded, nor financially aided, nor supervised by a paternal government, as were most European colleges, but were the offspring of private enterprise. In fact, almost every one of our colleges was a joint-stock company, composed of a few ambitious medical graduates. The maintenance of these colleges, including the salaries of the self-appointed professors, was wholly dependent on the number of students and the amount of their fees. Hence the colleges were

forced, in order to survive, to adopt such measures as would tend to increase the number of students.

The average citizen and his legislator were too ignorant of medicine to discriminate between the skilled and the unskilled doctor; hence our laws restricted no one, however ignorant, from the practice of medicine; none the less, the average citizen did prize a title, if authoritatively imposed, and so the M. D. diploma did have public value. For such reasons the average student strove to gain this title as promptly and cheaply as might be possible; and this vicious demand, the outgrowth of public ignorance, the medical colleges were forced to supply.

The multiplication of medical colleges and their consequent competition became excessive. Their doors were kept encouragingly open to all who wished to enter, regardless of preparatory education and almost regardless of any more serious requirements for graduation than a student might voluntarily impose on himself. The results of these unfavorable conditions were, on the one hand, a few medical colleges that had superior educational advantages and necessarily high fees; where a student could gain much knowledge, if he chose to do so, but also where the requirements for graduation were very inadequate. On the other hand, there were many colleges with few advantages, correspondingly low fees, and requirements for graduation insufficient to debar even the grossly ignorant from securing the M. D. degree.

As these evils augmented, resulting in an excessive overproduction of ill-educated graduates, so did the number of physicians increase who denounced these evils, and these enlightened physicians finally gained sufficient influence over public opinion to induce the legislators of many States to establish Medical Examining Boards, such as Louisiana established, July 4, 1894, with the approval and aid of members of our faculty. These boards have power to grant licenses to practice medicine to those alone whom these boards, and not the colleges, may deem competent. Thus, wherever such boards exist, the students and their colleges are bound to respond to whatever requirements these boards may enforce, and their requirements are at least superior to those previously imposed by an ignorant and negligent public opinion. Other causes have contributed to the recent great progress in medical education. General educa-

tion has increased the number of citizens able to appreciate the vast importance to the public welfare of medical knowledge; and the prosperity of our country has at the same time increased the number of those able to contribute financially or otherwise to the improvement of medical colleges. The facts now submitted will contribute to the better appreciation of the progress of our college as well as of other colleges.

From 1834, when the Medical College of Louisiana, the parent of our present medical department, was founded, until seven years ago, no evidence of educational qualification, preparatory to the study of medicine, was demanded of any student. This requirement, first enforced in 1893, was increased in 1898, but is still insufficient. The literary and scientific degrees, B. A., B. S., etc., of all colleges are accepted, and yet these degrees from some colleges fail to indicate as good an education as does the certificate of graduation of some high schools. The certificates of all superintendents of education are also accepted, and yet the certificates of some superintendents are valuable solely as illustrations of the extreme amiability and excessive elasticity of conscience of some of these State officials. None the less the present requirements are a decided improvement over the past.

From 1834 to 1893 attendance on only two annual sessions was required. These sessions were of only four months duration until 1879 when began a very gradual increase until every session was lengthened to six months in 1893. However, it was a frequent thing for some students to enter very late and leave very early and there were instances of barely longer attendance than sufficient to register, pay for the tickets and be present at the final examinations. It is true that all catalogues announced that three years' study of medicine was required for graduation, two of these years in a college and one in a doctor's office, but the certificates of one year's study with a preceptor were frequently worthless and were never enforced. I was graduated in 1853, only seventeen months after opening a medical book for the first time, and to prove how very little was then required, I was graduated, as no doubt many others were, by the unanimous vote and with the congratulations of the Faculty and no question was ever asked as to how long I had been a student of medicine.

Until 1881 there was only one annual examination and that was given solely to candidates for graduation. Until 1866 every candidate was examined by every professor on the same day, one professor following another, and each occupied so little time that in about an hour and a half all the examinations, to which any one student was ever subjected, were completed. These hasty examinations were exclusively oral and were never preceded by any reports, from laboratories or any other source, as to the amount and efficiency of any work done by the student. Brief as was the examination of every professor, part of his time was often devoted to kind inquiries as to the welfare of the student and his family! In 1881 were inaugurated examinations, at the end of the second session and of students who volunteered therefor, on the elementary branches, and at the end of the third session on the practical branches, thus greatly encouraging students to devote three collegiate sessions to study before attempting to graduate. Since 1881 examinations have gradually become more numerous and exacting. However, it was not until 1897 that written examinations were required, and not until 1898 that every student's record in every study was carefully kept and permanently registered. There are now frequent examinations during and also at the close of every session. In proof of how much more exacting our examinations and of how much better informed our graduates now are than formerly, it is found that, notwithstanding the longer and more numerous sessions and the much better attendance five times more candidates are now rejected than during the years (1851-3) when I was a student.

From 1834 to 1867 our college never had more than eight or ten teachers, instructing in only eight or nine branches of medicine and in only two laboratories, the two still of greatest moment, viz: the wards of the hospital and the rooms of practical anatomy. To these two laboratories there was added in 1887, by the valuable aid of the Tulane Administrators and of Prof. Ordway, a laboratory of Practical Pharmacy, with attendance therein obligatory on pharmacy students only; and in 1889 the Faculty established a Microscopical Laboratory for medical students, but a course therein was not obligatory until 1893. In this year not only were the anatomical and microscopical laboratories very greatly improved but two new laboratories (of chem-

istry and of operative surgery) were established and attendance in these laboratories was made obligatory. Comparing past and present in the above particulars it is found that, while formerly only nine different branches were taught and special courses given in two laboratories, now sixteen different studies are taught and courses given in five laboratories; formerly there were only eight to ten teachers, now there are forty-one, and yet we need and must have more specialties taught and more teachers.

The close of the war found our college in 1865 with many old books but without catalogue or index or house-room for them, nor could a proper room be provided until our new building was completed in 1893. For several years thereafter the attention and funds of the Faculty were more urgently needed for other improvements than the establishment of a library, but this was done in 1896 and it has since been annually improved. So that our college now possesses (in addition to some 1500 duplicates and other comparatively useless books in an annex) a well-organized and valuable library of reference, consisting of about 3000 properly accessioned and card-catalogued volumes. While most of these books have been donated by members of the Faculty, about $1500 have been expended in the purchase of others. This library is of great advantage to students and teachers.

Another indication of progress is found in the facts that even until 1885 the medical faculty never had on its pay-roll more than five, while it now has twenty-seven persons; and, although the number of our students is not twice as many as in 1885, yet the annual expenditures of the faculty have quadrupled.

While the professors, graduates and students of our college have most notably contributed to the great usefulness and repute of the Charity Hospital, yet the welfare of the Medical Department is still more dependent on the use of this hospital for the educational purposes that are secured by law to our college. Hence, every improvement of the hospital promotes the progress of medical education. These improvements have been great and numerous, but reference will be made only to the three that have most obviously contributed to the educational advantages of the Medical Department.

Two admirable buildings were erected in 1892 for Out-Door Clinics, and the result has been that the number of the sick,

seeking relief at the hospital and educationally utilizable, has increased from less than 10,000 to 30,000 annually.

As early as 1844 a large amphitheatre for surgical operations and for lectures was erected in the Charity Hospital at an expense of $5000, half of which was contributed by our Faculty. But this building became unfitted for its purpose, chiefly because of its ill adaptation to the requirements of modern sanitary science and especially of what is commonly termed "antiseptic surgery," one of the greatest of the numerous boons bestowed on suffering humanity by medical science. In 1895, a new amphitheatre, one of the best in the world, accommodating more than 400 students, was erected on the site of the old amphitheatre at a cost of $44,130, of which $3000 was contributed by our Faculty. The benefits to the diseased and injured and also the educational advantages of this building are incalculable.

In 1899 the Milliken Memorial Hospital, accommodating over 200 afflicted children, was erected as an annex to the Charity Hospital. For this unexcelled building the profoundest gratitude, not only of the people of this city and State but also of the Faculty of our Medical Department, is due to Mrs. D. A. Milliken. Nearly half of all deaths are of children under five years of age, hence the very great importance of the special study and teaching of their diseases, and neither can be thoroughly well done except in a special hospital. While many children have been and very many more will be, directly benefited by admission to this hospital, yet the number of those who will be indirectly benefited will greatly exceed the former. For, it should be remembered that our students, to be graduated, must have been instructed in this hospital, that thereby they will be enabled to bestow better knowledge and skill on every sick child entrusted to their care and that the number of children who will thus be indirectly benefited will surely exceed in number all those who will ever enter this hospital. Our future graduates will follow the footsteps of their predecessors and these are now to be found from Alaska to Florida and Cuba and from Canada to Mexico and the Philippines, and wherever they may go the care of sick children becomes one of their chief duties. May the thought of all the good to be conferred, indirectly as well as directly, by our children's hospital prove to be an endless source of consolation and of happiness to the self-sacrificing donor!

I can do little more than allude to various other causes that have influenced the prosperity and educational progress of the Medical Department. But, in addition to the influence of causes already indicated, such as "hard times," yellow fever and quarantines, medical examining boards and the Charity Hospital, there are two others, politics and donations, that have had most notable influence.

Our civil war, the result of politics, influenced our prosperity far more than any other cause. From 1834 to 1859 the number of our students increased from eleven to two hundred and seventy-six by normal growth. There then occurred during the next three years an abnormal increase to four hundred and four students in 1861, due to the political and sectional hostility that induced southern students to abandon northern colleges. War came and our patriotic students became soldiers in such number that the four hundred and four students of 1861 were reduced to only ninety-four in 1862. Our doors were then closed until 1865, for, during the three intervening years all of our students and all of their teachers, not too old for service, were Confederate soldiers.

From 1865 to 1885 the number of our students ranged from 230 to as few as 105 in 1875; about which time culminated the tyrannical and monstrous evils of the "reconstruction government," based on the negro, the carpet-bagger and the scalawag and upheld by the victors for the spoliation and humiliation of the vanquished South. A patriot, who lost in the battles of the South both a leg and an arm, had none the less enough of him still left to lead those who were determined at every risk to supplant a most vicious with a decent government. This was at last accomplished and the people of this State, the young as well as the old, should never forget the immense debt of gratitude due to their leader, Francis T. Nicholls, who in 1876 became the Governor, and is now Chief Justice of Louisiana. Despair was now replaced by hope, and prosperity began to return to this State and to our Medical Department.

From 1875 to 1901 our students gradually increased from 105 to 426, but it required twenty-eight years to recover from the abnormal conditions resulting from war and politics; for, it was not until 1886 that our college had fairly regained the number of students that had attended in 1858. During the many very

trying years that the very existence of this college was at stake, the members of its Faculty gave to it devoted and skilled labor for the remuneration usually paid to very ordinary clerks. Since 1876 politics have ceased notably to affect the Medical Department.

Our college has been the recipient of donations without which it could not have gained its present usefulness and prosperity. This aid has come from five different sources. In 1843 Louisiana permitted the Medical Faculty to erect the first building it ever owned, on a lot belonging to the State, on two conditions: first, that the members of the Faculty should give their services to the Charity Hospital without pay, instead of being paid therefor as had been previously done; and, second, that one beneficiary student from every parish should be admitted annually for the next ten years; and this was extended in 1853 to ten years more. The first condition has always been fulfilled, and the second condition was certainly fulfilled for the twenty years, and, as I believe, for thirty years. The number of students increased from 38 in 1843 to 100 in 1846.

In 1845 a Constitutional Convention, influenced chiefly by members of the Medical Faculty, ordained the University of Louisiana and adopted as its Medical Department the Medical College of Louisiana, the parent of our present college. Not until 1847 did the Legislature execute the Convention's decree to organize the University. This began its career with our college as its sole department. The Medical Faculty surrendered its building to the Law Department, then first organized, and was given a much larger building on a contiguous lot, where now stand the Crescent and Tulane Theatres. This building cost the State $40,000, and in addition, the State gave to the Medical Department, from 1850 to 1858, $43,500 for museum, apparatus and repairs. Of the $80,500 thus contributed by the State, war and time have left nothing except the lot now the property of Tulane University, and the Museum still the property of the Medical Department. However, the immediate result of the State's liberality was the gradual increase of our students from 100 in 1846 to 276 in 1858; and this increase would have been much greater but for the fact that during these eleven years, there occurred five of the worst epidemics of yellow fever that ever desolated New Orleans.

In 1884, the University of Louisiana became the Tulane University of Louisiana. Since then the Administrators have contributed in many ways to the welfare of the Medical Department, and if they have failed to do far more that might well be done, this has been due to the imperative need of all their inadequate income to establish an efficient Collegiate Department.

Since 1886, the Medical Faculty, besides paying all of the constantly increasing expenses, has appropriated to improvements $17,500, derived from fees that, in less fortunate years, were all used to remunerate inadequately the members of the Faculty.

In 1894, Dr. A. B. Miles bequeathed to the Medical Department $10,000, a pathetic reminder of his devotion to his alma mater, and a very sad and inadequate substitute for the very valuable services that death deprived him of the power to confer as our most efficient and popular Professor of Surgery.

The fifth and only other financial aid given to our college, was by far the most important ever contributed. Without it the educational progress that has been and will yet be made would have been impossible. May 9, 1891, the wife of Dr. T. G. Richardson, our valued professor 1858 to 1889, our honored Dean 1865 to 1885, donated a sum sufficient to erect a new building greatly superior in all respects to the old one, and especially in providing all of the laboratories that have become indispensable to medical education and that the old building could not supply. A sufficient sum to equip these admirable laboratories was also given. The administrators took possession of the lot, assigned by the State in 1847 to the Medical Department, and, in its place, provided, at an expense of $35,000, a much ampler and better site for the new building. This was completed and occupied in 1893 and will continue, for very many years to come, to be exceptionally well adapted to its purpose. From this donation of Mrs. Richardson will very surely result the inestimable benefits of a better education to thousands of medical students and, through them, relief to millions of those whom the anguish of disease afflicts and the shadow of death menaces.

Blessed is the university that has possessed such benefactors as Ida A. Richardson, Josephine L. Newcomb and Caroline Tilton; fortunate is the city that can add to this trinity such other

benefactors as Deborah A. Milliken and Margaret Haughery; and discredited should be the city whose men may fail to honor these public-spirited women or may fail to imitate their beneficent examples!

Consideration of past progress, especially notable during the past ten years, prompts the question—What of the future? It is very certain that, while much has been done much more remains to be done. The greatest need is the requirement of better educational preparation for the study of medicine. How best to accomplish this is a very perplexing problem. As long as a medical college is wholly dependent on the fees of students, the temptation to lower the educational standard, in order to secure more students, is too seductive to justify the expectation that the members of any faculty would inflexibly enforce a high standard, thereby diverting many students from their own college to competing colleges having a lower standard. By such theoretically desirable action the life of a good college might be destroyed, with no better result than to strengthen the life of the least efficient colleges.

The problem cannot be satisfactorily solved by entrusting the execution of the required high standard to outside authorities such as colleges conferring literary degrees and Superintendents of Education. If the execution were left wholly to such colleges, then those that may be efficient must be selected and even in these the subjects really preparatory to the study of medicine must be taught. The present action of some colleges and of some superintendents is now entirely satisfactory, but the literary degrees of many colleges and the certificates of many superintendents are otherwise and I have little hope of their reformation.

The only satisfactory solution of the problem, known to me, has, thus far, been accomplished by one State alone. New York has entrusted the whole subject to the Regents of the University of the State, so that no student can now enter any medical college in the State of New York without complying with the educational requirement of said Regents. It might now be perilous to our Medical Department if Louisiana alone should enact such a law, but if adjacent States, and especially Mississippi and Texas, would unite with Louisiana in such legislation, medical education would thereby be promoted to greater extent than by

any other one thing known to me. Of this much I am unhappily confident that I shall not live to see the day when Louisiana, Mississippi and Texas will become sufficiently enlightened to enact such a law. Hence I leave the solution of the problem to posterity, striving, in the meanwhile, to do the best that present conditions may render practicable.

In addition to this most needed reform the following others must in time be accomplished. Four annual sessions should be required even of those who have literary degrees; every one of these sessions should be gradually lengthened to eight months; the studies of every session should be better graded; the fees should be as high as in England and in a few American colleges, so as to provide the very best educational advantages; in addition to written examinations, every student should be subjected, not merely on some but on all subjects, to examinations that would test his practical knowledge and, man's highest faculty, his judgment, tests for medical practice more important than the memory of text-books and lectures, for, memory merely gathers facts for the action of judgment and is everywhere too much relied on as the only final test; there should be more recitations from text-books and fewer lectures; the classes should be sub-divided into more numerous sections, so that student and teacher may be in closer communion; more specialties should be taught; there should be some elective studies, probably in the third and certainly in the fourth year; there should be more professors and teachers; professors and all teachers should be given fixed salaries and none of them should be subjected to the enervating influence of dependence for their livelihood on the number of students and the payment of their fees; finally, I concur with my eminent deceased friend, Randall Gibson, long both U. S. Senator and President of Tulane's Board of Administrators, that either the salary of every Professor of our University should be increased, or that every one of them, who may have satisfactorily served a certain term of years, should be entitled to a pension.

At the bottom of these reforms lies the grave question: To what extent can our Faculty strive to lead, in medical education, professional and public opinion without impairing the prosperity of our college? Adaptation to surrounding conditions and to the means possessed to execute reforms is indispensable to accomplish them.

To accomplish all desirable reforms money, and much of it, is indispensable. How much may yet come to our Medical Department may possibly be foreshadowed by the following facts: one Northern medical college has "grounds and buildings" valued at $2,000,000: Hoagland, Loomis, Carnegie, Senn and others have each given tens of thousands of dollars to promote medical education; citizens of Boston have given to the Harvard Medical College and citizens of Philadelphia have given to the Medical Department of the University of Pennsylvania hundreds of thousands of dollars; the Vanderbilts have given over $1,000,000 to the Medical Department of Columbia University, and, in 1898, Oliver H. Payne gave to the Medical Department of Cornell University $1,500,000.

One thing in the future is very certain, New Orleans ought to become a much more important centre of medical education than it is. Grossly ignorant critics and silly scribblers have often commented unfavorably on the needlessly great number of our students and graduates. The most recent report of the United States Commissioner of Education (1899) gives some facts on this subject, worth the consideration of the wise. In 1899, the 122 regular medical colleges in our country had 21,401 students and 4314 graduates, and twenty-nine homeopathic and other such colleges had 2377 students and 597 graduates; eight of the regular colleges had over 400, and one of these had 938 students; Louisville had 792, Nashville had 948, while New Orleans had only 392 medical students and eighty-eight graduates. Our city, the twelfth in population in the United States, did not have even one-sixtieth of the total number of medical students. Our college can now accommodate 500 students; by reducing our requirements for graduation our building could be filled to repletion, and by reducing, at the same time, our fees, an additional building would be needed to accommodate all who would strive to enter our doors.

Various causes contributive to the progress of the Medical Department have been considered. However, to the close of this address has been deferred reference to one other important cause, viz: the services of the members of the Faculty. All of the thirty-three professors, whom our college has had, have been personally well known to me with the exception of eight whose services were ended by death or other cause prior to 1851.

Three even of the founders were first my teachers, then my colleagues so that I have had ample opportunity to learn much of every professor who has ever served our college. Some of these professors, now no more, were remarkable for exceptional ability, and our Faculty has, in the past, always been fortunately composed, in greater part, of members pre-eminently qualified for their positions.

These qualifications are: superior special knowledge, with capacity and experience to impart this knowledge, both as speakers and as writers, instructively and attractively, not only to students but also to the medical profession and the public; character and ability sufficient to secure not only the respect and affection of their students but also professional and public distinction; sense of duty high enough to sacrifice private interests to official collegiate duties; and force and energy abundant enough to supply the greatest need of every faculty, the need for the very few who can increase its strength and not for the many who may gain strength but lack it to give.

My knowledge of those who possessed pre-eminently all of these qualifications and of their invaluable services to our college floods my memory with such admiration, love and gratitude, that it would be ignoble, in a record of progress, to ignore the dearly loved and honored friends to whom this progress is as much, and even more, due than to any living men.

In behalf of my present colleagues, propriety permits me to testify that no previous Faculty have ever been composed of members more laborious, self-sacrificing and devoted to their collegiate duties; and that, owing to more favorable conditions, no previous Faculty has ever had the great, good fortune to be able to claim such notable additions to the educational resources and progress of the Medical Department.

Before graduation, I stated my intention to strive to fit myself to become a professor in this college; and my two years as a student together with my forty-three years of official service the last sixteen of these as Dean, have developed a love for, and a pride in the Medical Department that have induced me to devote to its welfare the chief labor and ambition of my life. Harrassing as my duties as Dean have often been. my yoke has been made comparatively easy and my burden light by the good will, and in many instances more than the mere good will, of my

students, and by the cordial support of my colleagues. It is questionable whether any faculty ever had so little to complain of and so much to commend in the conduct of its students, so little dissension within itself and so much unanimity in feeling, judgment and action. For such reasons, I can not refrain, at the close of this historical sketch, from expressing, with a very grateful heart, my ardent thanks for the unceasing encouragement and support given me by those who have been my best friends, my colleagues and my students. Without their support my labors would have beeu fruitless and my ambition would have yielded only humiliation; whereas my good friends have enabled me to recall the many years of my collegiate service with some degree of satisfaction.

PTOMAIN POISONING; DURATION OF CASES IN CHILDREN.*

By L. G. Lebeuf, M. D., New Orleans.

Ptomains can be described as substances resembling alkaloids generated somewhere in the intestinal canal or the alimentary tract by the putrefaction or decomposition of nitrogenous foods. They may be caused by decomposition of tissues after death, or may be due to certain fermentative processes of microbic life in the live subject. The human body, in perfect health, is an immense laboratory, perfect in its working, minute in its details of function, which is continually generating and forming poisons or toxins which it as rapidly throws out. If the ratio and proportion of the formation and destruction of these poisons keeps up naturally, and the elimination and destruction of these bacteria happen as rapidly as their formation, then the human body has no risk to run; but if the food we take is in excess of the quantity needed, if the oxygen is diminished, or by lack of exercise or outdoor life the eliminative organs—the liver, the kidneys, the mucous membrane of the intestines, the skin, etc., are rendered sluggish in their action, the toxic products accumulate too fast and the system is rapidly rendered toxemic.

To illustrate, urea is a product of normal tissue waste, which generally is eliminated without any difficulty in a proper soluble form; still we know that the human body in health should

*Read before the Louisiana State Medical Society Meeting, April 18, 19 and 20, 1901.

eliminate about 511 grains per 24 hours. If by some process of improper oxidation or by some general or specific renal disturbance, this elimination is checked, this product, urea, being a virulent poison to the tissues. It has been calculated chemically that a human body of 150 pounds in weight can be destroyed in two days of poisoning or intoxication by the individual product of this same body.

Bouchard states that auto-intoxication is a poisoning of the organism by the products of its own metabolism, which products may be normal in character, but excessive in quantity. By this opinion we see that the human body is both a manufacturer and a receptacle of poisons. We find them in nearly all the foods; they are generated during the process of digestion, they are contained in the secretions of the body; they are found everywhere; and the wonder is, how does the individual remain healthy surrounded by this anarchy of forces, in this Black Hole of Calcutta?

The secret lies in the admirable physiology of the human body; in the continuous retrograde chemical action of all our organs. Here exists a beautiful equilibrium of all the organic forces. Some organs and functions are actively at work manufacturing poisons, while others are busy eliminating them, arresting them, or changing them to harmless products. Some thinker has called these the "Organs of Defence," for on them rests the important duty of disposing or neutralizing the continuously forming poisons of the body, to protect that very body.

These organs of defence, in an admirable balancing of animal function, may be always in perfect behavior and accomplish all that is expected of them; still, allow for one instant any irregularity of these functions, allow any derangement of the internal law of equipoise, and the whole structure is shaken or shattered. Some one has divided these organs of defence in two classes:

1. Organs of transformation or arrest—they are the liver, the gastro-intestinal membrane, the spleen, the lymph nodes, adrenal bodies, the thyroid gland, etc.; their responsibility is to check, arrest or modify the production of germs, to render them innocuous; they are the body's great filter.

2. The organs of elimination are the kidneys, the lungs, the skin and the intestines; their function is to remove from the

body and the circulating fluids of the body all the toxic substances which may have escaped the organs of arrest, or which may have formed in the system in other tissues after they have passed these organs.

This is a beautiful hypothesis—not only invented to make pleasant reading, or to satisfy the imagination, but it is built on the firm foundation of truth, a monument of porphyry or Parian marble to the memory of the noble pioneers in the science of experimentive bacteriology and physiologic chemistry.

The discovery of this decomposition of micro-organisms forming ptomains was made nearly at the same time by a Frenchman, Armand Gauthier, *Professeur de la Faculté de Paris*, and by an Italian, in Bologna, Selmi; the latter was led to this discovery while making a medico-legal analysis of the viscera of an alleged case of criminal poisoning. During the course of this examination he found some very toxic alkaloids, and he immediately deduced that these were products of fermentative processes in putrefaction itself.

The constitutional symptoms caused by the poisons of many infectious diseases, and apparently originating in the blood, are attributed to leucomains; they are, as it were, results of intracellular changes in the human organism. While on the other hand, those which arise from the action of saprophytic bacteria of the stomach and the intestines are called ptomains from *ptoma*, cadaver; they are certain basic or organic compounds which are formed by the action of bacteria on nitrogenous matter.

The artificial culture of these micro-organisms show that they can create some substances with distinct physiologic action, at the same time they are frequently quite poisonous. Brieger between 1882–88 after innumerable experiments found that these ptomains were toxic and he called them toxins. He was able to isolate the different pathogenic bacteria of putrefactive poisoning. He established the axiom that these bacteria, or specific micro-organisms, caused disease by producing chemical poisoning. This gave the etiology of infection, and hence the impetus to the serum antitoxins, the greatest achievement of the *fin de siècle*.

The brilliant stars that have been elucidating this subject ever since have filled a distinguished firmament of original ex-

perimentation in organic chemistry and bacteriology. I will merely name Pasteur, Koch, Eberth, Laveran, Sternberg, Klebs, Lœffler, Vaughan, and you will remember the titanic labors each has accomplished.

If it is a recognized fact that fermentative and putrefactive bacteria are present all the time in the alimentary tract, then, certainly under certain influences, affected by outside effects their activity must be often greatly augmented. It is in a sudden change of this kind, acting upon some special nerve centre, or affecting even the absorption of the toxins, that we see disease so often produced, with poisoning or fever resulting. This diseased condition must be due both to the alterations in the digestive secretions, and in the character of the food ingested. We may easily explain in this manner most of the febrile disturbances which we are accustomed to attribute in children to errors or disorders of digestion.

Where before we believed the disturbance of teething to be wholly a reflex neurotic condition, following improper feeding, to-day we must consider the toxic etiology of ptomain poisoning. Hence simple pyrexia may have a specific cause from food eaten in an improper state of preservation, or by the effects produced during the process of final digestion of that food. Some years ago the Charity Hospital staff will remember how a little negro boy living a few blocks from the hospital used to get regular convulsions on every Sunday, during the course of two or three weeks, caused by over-feeding Saturday night. The ambulance used to take him to the hospital, where his stomach was pumped out and laved of large boli of salt meat. How many of us, after having a certain number of years of experience, can remember at least a dozen cases of night calls, where we were disturbed to relieve conditions, formerly called pure indigestion, or even cholera morbus. We would most times find a patient writhing with pain, between 8 and 10 hours after eating some canned goods, oysters, or some other unwholesome food; the pulse quick and excited, slightly dilated pupils, frightful nausea, violent purging, great gastro-intestinal disturbance, considerable depression, cold extremities, great pain and extreme anxiety.

I believe if we studied these cases thoroughly we would recognize a real ptomain poisoning in most of them. The patient

is slow in his recovery and remains depressed for a very long time, and often he has a very high range of temperature which does not seem to answer to ordinary antiseptic treatment until he is placed under a systematic course of intestinal antisepsis.

I wish to relate three or four cases which have come under my observation in children very lately.

The chemical laboratory and the bacteriologists have succeeded in isolating and classifying hundreds of these germs of decomposition, they can positively say what ptomain cream cheese can produce, which one fish will produce, or meat, or milk, and it is a beautiful study.

Still this study belongs to specialists and I am not in a position to elaborate upon it. Vaughan, specially after his discovery of tyrotoxicon, has made some admirable researches in the matter. I merely want to illustrate the cause of the cases I saw and ask you to deduce the same conclusions I have arrived at:

Case No. I. A white female child, 4 years old, strong, healthy, robust, was taken sick on December 19, with vomiting and purging and considerable pains in the abdomen. I saw her on that day, her temperature was 101 deg. and I prescribed some little, simple treatment according to the indications. The history given then was that the child had eaten the night before some cold cabbage with probably some small piece of salted meat. I saw the child for a day or two, and still the fever kept on. The child was very much depressed, dull, sleepy, with the abdomen very much distended, tympanitic and painful in the region of the epigastrium.

December 22, the temperature rose to $104\frac{2}{5}$ deg. and the child seemed very sick. I placed an ice pack to its head, and next morning temperature being still 105 deg. I also placed ice bags to the abdomen, besides using sponging.

The temperature would be reduced by these means but only one or two degrees, and December 23 it was still 104 2-5 degrees. The abdomen was like a drum, tympanitic and painful, so the child was then placed upon a combination powder of

Hydrarg. chlor. mitis	gr. $\frac{1}{10}$
Sod. sulphocarbolat	gr. ss
Bismuth salicylat	gr. i

M. et Sig. *ter in die.*

and quinin and salol, 2 grs. each, were given every 4 hours. The temperature was gradually reduced and in a few days it

was normal. Whenever the antisepsis caused constipation, then it was stopped temporarily and calomel was given, in gr. $\frac{1}{10}$ dose every hour until catharsis was produced; once this had to be helped by a large enema of sulphate of magnesia.

Case II was in a little child 12 months of age. It was taken sick during the night of January 16 with severe cramp, temperature 105 deg., which answered readily to treatment. January 20, child's temperature was 99½ deg. and it looked better. January 20, I was called to child to find it with a temperature of 104 deg., very restless, pulse fast and rising, abdomen very much distended, actions frequent and most offensive in character; child had been nursing mother and was taking two or three bottles of milk a day up to this time. I stopped this form of feeding and placed it on Nestlé's Food. Used ice pack and small calomel powders, still the temperature kept up.

January 21, temperature 102 deg. at 8 A. M.; 104 deg. at 3 P. M.; 106⅗ deg. at 8 P. M.; 105 deg. at 9:30 P. M.

January 22, temperature 102 deg. at 8 A. M. 103 deg. at 8 P. M.; 104 deg. at 10 P. M.

January 23, temperature 102 deg. at 8 A. M.; 24, 102 deg. at 8 A. M.; 25, 102 deg. at 8 A. M.; 26, 104 deg. at 8 A. M., 105 deg. at 10 P. M.

January 27, temperature 103 deg. at 8 A. M.; 104⅖ deg. at 10 P. M.

January 28, temperature 103 deg. at 8 A. M.; 29, 102 deg. at 8 A. M.; 30, 103 deg. at 8 A. M.; 31, 101 deg. at 8 A. M.

February 1, temperature 104 deg. at 8 A. M.; 2-3-4, 100 deg. at 8 A. M.; 6-7-8, 99 deg. at 8 A. M.

This little patient did wonderfully well as soon as general antiseptic treatment was discontinued and plain mercurial catharsis with intestinal antisepsis was adopted.

Frequently during this range of temperature, the child's bowels became bound up and abdomen very much distended, whenever it did so, specially one day, January 21, when it was 106⅗ deg., the temperature always went up very high, and the child seemed to suffer considerably with pains in its head and in the abdomen. Nearly the same course of treatment was used. Continuous intestinal antisepsis with small doses of salol, sulphocarbolate of soda and gentle catharsis with mild chloride of mercury. This always seemed to relieve it and reduced temperature. Twice when the temperature reached its highest point, I used also large rectal douches of normal saline solution at about

75 to 80 deg. of temperature to help to lower the height of the fever. Diet was limited to milk entirely sterilized, Ducro, barley water and chicken tea.

Case No. III. Was a little child who was still nursing, 3 months of age. It was taken with high fever, purging and vomiting January 21. Child was a well nourished, vigorous baby, whom I had delivered and had followed and directed during the entire period of its feeding and development. Two or three times before its mother's milk had apparently disagreed with the child; it would vomit its milk in curds, and have frequent spells of loose bowels. The mother's milk had been interrupted and the child placed on Nestlé's Food and Horlick's Malted Milk two or three times; still, just before its illness we had gone back to its mother's milk, and he seemed to have thriven very well on that for a month or so; he had become stout, the actions had been well digested, and the stomach seemed better. When taken sick on January 22, child was constipated and had a temperature of $103\frac{2}{5}$ deg., and in spite of forced catharsis bowels remained bound up.

January 23, fever very high. Temperature $104\frac{4}{5}$ deg.; bowels were moved and temperature went down in evening to 101 deg.

January 24, temperature went up again to 105 deg. and child was taken with violent unilateral convulsions, these convulsions with short interruptions of a few minutes, lasted until the time of its death, January 26, after 40 hours. Every thing was done to arrest them. Hot baths, mustard, bromide and chloral by enema, etc. Still the auto-intoxication seemed so great that even when the bowels were made to act freely and under the effect of some drug the child became quieter, in a few minutes they would return more violently than ever, and finally the child died. There must be some direct cause of cerebral irritation in the absorption or damming back of these special germs of milk decomposition in the intestines. This toxin must also act either directly or indirectly on the vaso-motor reflexes. Quite a pronounced condition of urticaria was noticeable in these two last cases about the face and over the abdomen; in case II also around the genitals.

Since the experience of these cases I saw a little child of about two and a half years in a sudden violent convulsion, without any previous fever or any antecedent sickness. After controlling spasm, I removed with the finger large caseous scybala

of fecal matter which seemed to have caused an impaction in the lower rectum; after flushing the bowels with a large enema the child was soon all right.

Nearly all the cases of headache from constipation must be in a sense due to auto-intoxication, or ptomain poisoning. I regret that the scope of this article does not allow me to go into the subject any further, because, I believe that we should take this entire subject more seriously than we have yet done.

I have heard a distinguished gynecologist state, that the day would come when it will be admitted that the etiology of eclampsia lies in the damming back of some alkaloid poisoning on the large nerves centre.

Stomatitis has been caused by these alkaloids, severe inflammation of the Eustachian tubes, abscesses in almost any part of the body frequently result from them. Though the bacteriologists have been able to classify a great many of them, a hundred or so, nearly as many as we have kinds of nitrogenous foods, the prevention of their toxic effect has not been yet discovered, or if discovered has not been properly applied. Still, in this great age of serum therapy we may expect it soon, and the day will yet come when we can inject our bodies with the serums of prevention against the dangers from any kind of food decomposition. In the meanwhile until we can use an antitoxin against the tyrotoxicon, for instance, to protect our little weak suffering babies, let us at least always give them the benefit of the use of our general intestinal antisepsis.

BIBLIOGRAPHY.—Keating's "*Diseases of Children*," Vol. IV.
Sajou's "*Annual*," Vol. IV.
Gilman Thompson's "*Practical Dietetics.*"
W. M. Perkins' "*The Evolution of Serum Therapy.*"
J. Bouchard, "*Sur l'Autointoxication.*"
Wood's "*Reference Handbbook of Medical Sciences.*"
P. Larousse, "*Grand Dictionnaire Universel.*"

DANDRUFF—ITS TREATMENT.*

BY J. N. ROUSSEL, M. D., NEW ORLEANS.

The word "dandruff" has for generations been associated in the minds of both the profession and the laity with those condi-

* Presented to the Louisiana State Medical Society, April 20, as Chairman of Section on Dermatology.

tions of the scalp in which scaling forms the most prominent feature. Hence, my reason for retaining the term, if one is needed.

Since the time of Hippocrates this subject has received the attention of the medical man, most probably because of its baneful effects upon the growth of the hair. There is nothing which enhances youthful beauty so much as a fine head of hair. Beautiful hair has always been considered the chief ornament of the head. It has been the theme of poets in all ages and all lands. Guido and Raphael have painted it in all of its glories.

There is not a voluptuous or luxurious scene in poetry or romance in which a description of the hair is not introduced. Homer, in mentioning the celebrated fair one who set all Asia in arms, always called her the beautiful-haired Helen.

Without this ornament, the goddess of beauty, though possessed of the brightest eyes, and the most fascinating charms, would appear hideous and deformed. The toilet of the hair is no less an important affair now than in ancient times, and in their eager desire to beautify their heads, women, and men alike, do irreparable damage to their scalps by using the various nostrums which are advertised as certain cures for dandruff.

The number of "certain cures" are legion, and usually do harm by lowering the powers of resistance of the tissues, thereby rendering them a prey to the army of parasites that "lie in wait" as it were, for a chance to get in their work upon the scalps of the unwary. This they do with a regularity that is particularly distressing, to which the very large number of sufferers can amply testify. Yet these very same individuals move on serenely listening to the sage advice of omniscient barbers, whose education along other lines I trust, has been less neglected.

The chronicity of dandruff is almost proverbial, and while many have struggled with the problem of its treatment, for lo! these many years, to use the hackneyed expression of Mr. Watson, of Georgia, "We dont know where we are at" yet. This may be putting it rather too strongly, but we are all aware that the majority of us all are still groping in the dark, in spite of the fact that Unna, with his wonderful knowledge of things dermatologic, many years ago, lifted the subject out of the ob-

security to which it had been relegated by years of inactivity along those lines.

The subject of dandruff has been considered under various names, and many were the theories regarding its etiology, but it fell to Unna to shape the matter more specifically, which he did, as far back as 1887.

In the *Journal of Cutaneous and Genito-Urinary Diseases*, for December, 1887, there appeared Unna's justly celebrated article on this condition, which he was pleased to call Seborrheal Eczema for histo-pathologic reasons.

Many writers since that time have taken exception to the term, arguing that it was neither a seborrhea nor an eczema, but none have ventured to deny the truth of Unna's statements relative to its parasitic nature, or to its histo-pathology, both of which are of inestimable value in shaping some plan for its treatment.

I feel strongly with John Hunter that "definitions are the most damnable things", but they are a necessary evil, and whether Unna was right in calling the condition seborrheal eczema or not, is a question that does not concern us at present. However, I might say, *en passant*, that the condition is a complex one, and resembles a seborrhea, or an eczema, about as closely as any hybrid is likely to resemble the varieties, from a blending of which it results. At the same time, and for obvious reasons, it may not be unwise to remember, before proceeding to its treatment, that the condition is not a *true* eczema, nor is it a *true* seborrhea.

You will, surely, all recognize it on sight. Its evolution may be slow, and indeed, it is usually slow, especially, the scaling, or squamous form which is most often seen. This is true, I believe, most probably, because this form is a late manifestation of the disease.

The majority of writers are not disposed to take this view, however, and as a result, we have at least three forms described in the text-books on skin diseases. Elliot of New York, who was probably the first to call attention to the subject in this country, in his most comprehensive article in Morrow's System of Dermatology describes these forms as papular, round, or oval, or nummular discs, and circinate, gyrate or polycyclic bands.

The last two are most often seen, and are recognized, generally, by variously segmented, gyrate or flower-leafed efflores-

cences, sharply limited, scaling and of a pale pink color, or much reddened, with a slight yellowish tinge. The scales may be large and numerous, forming thick adherent masses simulating the desquamation of psoriasis, but should there be a complicating seborrhea oleosa, the scales are greasy, the follicular apertures are patulous and the skin more or less congested. This latter condition, however, is comparatively rare in my experience, and, I venture to say that it will only be found in those cases to which an irritant has been supplied, and is, hence, a pure dermatitis intervening.

The vertex is the usual seat of the disorder, although the affection may involve the entire scalp, and in the course of time, probably years, the hairs become dry and lustreless, from which a certain amount of baldness results. This condition, known as alopecia pityrodes, depends, according to Unna, not on an atrophy of the papillary hairs, but on their diminished new formation. The cause of this, speculators in the realms of that branch of pathology are disposed to believe, is a diseased condition of the follicular epithelium, induced by the action of a parasite.

The organism is endophytic in nature, and this point is of material moment in arriving at a method for its treatment, and more particularly, the character of agents to use. Being endophytic we would naturally seek them below the epidermis, and in truth, the affection is subepidermic, but we are not yet prepared to make any but general statements relative to the real seat of the disorder, and the exact conditions existing, for the reason that on this point, the most competent pathologists are still unable to agree.

The organism being an endophytic parasite, and located, most probably in and around the hair follicles, the proposition follows, and I wish especially to make a point of this fact, that kerato-plastic agents in general are particularly contra-indicated. The reasons for this are obvious.

It is a well known fact that all of the so-called kerato-plastic agents are non-diffusible and coagulants of albumin, and especially keratin, and as a result the organisms are being protected by a plastic coating from the further action of the agents intended for their destruction.

Were this organism of a similar nature to the trichophytes, or in fact were they epiphytes, then I could conceive of the ration-

ality of the use of agents with a kerato-plastic action, for it is well known that an agent that possesses the power of inducing an acute exfoliative dermatitis, as it were, will interrupt the ravages of the epiphytes. Hence, ringworms of short duration are generally quickly cured, but when the parasite has invaded the hair follicle, it is often a matter of weeks before a cure is affected, and this is in all probability not accomplished by a destruction of the parasite. The process is probably one of simple exfoliation—for the reason that we are not by any means certain of our ability to destroy the parasite by these measures. Besnier goes so far as to say that ringworm can be cured only by inflammation—what he calls a curative dermatitis must be set up—so there is, in his opinion, no remedy at our disposal that is capable of destroying the fungus.

Now, if this is true with the ringworm-fungus it may, with equal propriety, be true for the parasites of dandruff, and certainly those of us who have to dispense advice to dandruff sufferers are amply justified in coming to that conclusion. However that may be, we are certain of the one fact that they live long and prosper, in spite of our best efforts to destroy them.

It has been the belief, since the time of Homer, that "those whom the gods wish to destroy, they first make mad," but I assure you that this procedure will not subserve our purpose in this particular instance.

Of the numerous remedies that have been suggested for the cure of dandruff, sulphur and resorcin seem to constitute the favorites, with the honors about evenly divided. They are usually prescribed in the form of lotions, preceded by a shampoo of the tincture of green soap.

Elliot states that lotions are more useful on hairy parts, and I believe that my eminent friend Dr. Dyer is of the same opinion. Hardaway thinks differently, however, and I am disposed to agree with him, in a measure.

I have been very faithful in my attempts to cure dandruff with sulphur and resorcin, and also with the mild chloride and ammoniated mercury, as recommended by Dr. Bronson, but, as yet, I am very dubious as to their real value.

My experience is, that if we count our successes with any treatment by the number who fail to return after the first or second visit, we could all evince much enthusiasm over the re-

sults of almost any treatment. In truth, a very few ever return, for the reason that the average person is usually satisfied to have obtained temporary relief, and the balance are of that impatient and easily discouraged class of individuals who, either through the importunity of omniscient friends or the satisfying impression that you are ignorant of some imaginary special feature of their case, seek the advice of somebody else.

Not being satisfied with the results obtained from the use of the agents above named, and believing that the pathologic conditions existing in dandruff were, in a measure, similar to those of a trichophytic folliculitis in which the hyposulphite of soda yields such delightful results, I was induced to try it in the treatment of this affection. This I did, with results that were very gratifying indeed; but, as yet, I am not prepared to state positively that any of the cases, in which I used it, are entirely well. I am certain of one thing, however, and that is, that this agent certainly gives more relief in less time, and is less disagreeable to the patient, than anything else I have ever used. How it acts, I am not prepared to say. Miquel has determined that it is antiseptic in the proportion of 1 to 3. This indicates very feeble powers, and certainly discountenances the extravagant claims of Olli, of Milan, who was disposed to vest it with wonderful antiseptic powers. However, this does not concern us clinically, so long as it subserves our purpose, which, in my experience, it does.

I usually prescribe it in a 25 per cent. solution, and direct that the hair be cut short (not shaved), and the solution applied continuously, by means of pad of absorbent cotton saturated with the solution. The time required will vary with the individual case, but a week will usually suffice to bring about an amelioration of the condition that is not done in a week or weeks with other agents. I have not found that the drug produced any unpleasant local symptoms; however, I could well imagine how a continuous application of any agent to the skin for so long a time might do so.

If there is any accumulation of scales, and, particularly, if there are any scabs or crusts, I am in the habit of ordering the head shampooed with any kind of soap, giving the preference, however, to green soap, on account of its alkalinity. The head, however, must not be washed too often on account of the harmful effects of soap and water.

I insist that the continuous application of the agent, in solution, must be made, for the reason, that we can only expect to reach the bailiwick of the parasite by means of osmosis and for osmosis to take place, at least three things are necessary, viz.: two fluids and a membrane intervening.

I fully realize that the continuous application of the agent as herein recommended, is a recommendation not easily carried out, in the great majority of cases, but that it is a necessity, I am firmly convinced.

Clinical Report.

SCARLATINA AND DIPHTHERIA—A CASE WITH BACTERIOLOGIC EXAMINATION—REMARKS ON ANTITOXIN.*

BY E. M. DUPAQUIER, M. D., PROFESSOR ON CLINICAL THERAPEUTICS IN THE NEW ORLEANS POLYCLINIC, ETC., NEW ORLEANS.

About two months ago, G. C. M., white boy, aged 4 years, was brought to my office, wrapped in his mother's cloak. The child was pale and looked seriously ill. His mother told me that the day before he had vomited, and since that time high fever had set in, with sore throat. The temperature was, in the rectum, 104 F., not corrected; the throat was much inflamed. Both the chest and back were covered with large areas of scarlet rash.

As usual, in fever cases, I ordered:

1. Calomel, 15 centigr., to be taken immediately, and to be followed four hours later by 20 *c.c.m* of castor oil.

2. Six tablespoonfuls of raw milk, to be given in alternation every hour, with as many tablespoonfuls of cool water, prohibiting any other food or drink.

3. An enema of cool water, one quart given every four hours.

I told the woman to carry her child back home, to put him to bed at once.

That same morning I reported the case as one of scarlet fever.

I saw the child in the afternoon and found the condition of his throat worse. The next morning I noticed that there was an

*Read before the Orleans Parish Medical Society, April 27, 1901.

oozing from the nose of clear mucus, that the nares were irritated, pink at the edges, and that the child's neck was enlarged. On examining his throat I found two white patches on both tonsils. *The rash had disappeared almost entirely.*

I quickly got a culture tube, inoculated it with mucus from the nares and from the throat. I went directly to the medical college laboratory. Dr. John Archinard made a slide from the fresh specimen, and all those present who examined it distinctly saw in the field three Klebs-Lœffler bacilli, two streptococcic chains, and one staphylococcic group.

I hurried to the Board of Health, reported the case as being now one of diphtheria, explaining my mistaking it for scarlet fever, and asked for some antitoxin, the patient being a pauper. I hastened to the child's bedside and promptly injected 3000 units of the P., D. & Co. standard antitoxin.

The running from the nose was at that time remarkably increased; a muco-purulent discharge oozed out from the internal angles of both eyes, and the larynx was becoming involved.

Twenty hours later, hardly any change being perceptible, I injected again 3000 units of antitoxin.

In the following twenty-four hours the improvement began, generally and locally, and afterward it continued, leading to a rapid and uneventful recovery.

The local treatment consisted of the spray with camphor-menthol 3 per cent. solution in glymol every hour, through the nose and mouth. No desquamation ever occurred.

Remarks.—The invasion of diphtheria is often accompanied by a scarlet rash which in times of scarlet fever spread may prove very misleading. It disappears when the pharyngeal, nasal, laryngeal and ocular localizations of diphtheria are manifestly established. The scarlet fever rash on the contrary usually extends, becomes diffused and intensified, even in *anginose* scarlet fever. But, in the latter form with little or no scarlet rash "the appearances closely resemble diphtheria, so much so that many yet regard this state as a combination of the two diseases, but it is proven by bacteriologic studies to be due to the streptococcus, and only very rarely to the Klebs-Lœffler bacillus (pseudo-diphtheria). Late in the disease, after the subsidence of the primary fever, true diphtheria may also co-exist." (Taylor and Wells, Diseases of Children, page 584).

In the case reported, we find the Klebs-Lœffler bacillus and the streptococcus, but there *never was any desquamation*, and the test of pure diphtheria, the antitoxin, proved it was a case of diphtheria, by its rapid specific good effects.

I am an advocate of the free use of antitoxin, being convinced from the experience of honest observers who have used it in thousands of cases that large doses cannot do any harm; no ill-effect can be traceable to it. I am an advocate of a prompt, early and deliberate use of it, even in doubtful cases, since it can not hurt. While discussion is still going on as to the regulation of antitoxin dosages, I will say that if a small infant were severely infected with diphtheria I would not consider his age, but at once I would give him a 3000 unit injection, so confident am I that reliable antitoxin can not hurt. I therefore base the strength of the injection not on the age, but on the severity of the case.

Antitoxin in diphtheria is our talisman. We can watch diphtheria coming and stand watching complacently, with a broad smile. What a source of satisfaction for us of the present generation! And for all the blunders that I may make, while I am always well meaning, I will always feel a deep consolation in this, that I have contributed in introducing and testing, in our city, the life-saving antitoxin.

N. O. Medical and Surgical Journal.

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

DOCTOR GAYLORD'S WORK UPON THE CANCER PROTOZOON.

The speculative theories of the parasitic origin of cancer, engaging the attention of pathologists and bacteriologists of every land, have borne fruit in recent years.

The daily press has heralded the discoveries of Dr. Harvey R. Gaylord, of Buffalo, and the May number of the *American Journal of the Medical Sciences* devotes considerable space to the first authorized publication of the author's researches.

These are presented with all the clearness and exactness which characterize the careful technic of modern laboratory methods.

The article referred to elaborately reviews in honest criticism the work of others who have approached and labored in this special field and where points of difference are patent, these are discussed and met with earnest argument and proof.

A careful perusal of the text carries the reader through the history of special experimentation and impresses upon him the deductions of the writer.

While full of technic allusions and marked with the relation of precise laboratory detail, the remarkable merit of the work as presented deserves the notice of all medical men, interested in and looking for the explanation of so longtime a burden upon the skill and patience of the profession.

Departing from any attempt to analyze the argument with which the author defends his claims of exact findings over the claims of those who have preceded him, we wish to present his conclusions in their relation to the future consideration of cancer as it may bear upon the individual.

In all examinations of positive outcome, a fixed and definite organism was determined, having distinct characteristics, belonging to the group of organisms classed as protozoa. The specific

organism presented its own habits of development in culture media and upon inoculation in lower animals, the guinea-pig especially, from which the protozoon was recovered in all of the organs of the body.

The protozoa of cancer as presented by Dr. Gaylord resemble fat in the fresh state, but fails to stain black with osmic acid; these bodies are spherical and highly refractive and are found in number where they occur; they are nucleated and seem to pass through a cycle of development into what appears to be a sporeforming stage.

In all rapidly growing tumors, especially of large size, a great number of organisms were found; in small tumors only smaller forms of the organisms were seen; tumors and organs removed from cadavers dead of carcinoma or sarcoma showed the presence, especially in tumors, of great numbers of the organisms in all stages of development.

In special tumors so examined, successive scrapings, several hours apart, showed the relative size of the organisms gradually increased; in ten hours ameboid forms greatly increased in number; after twenty-four hours the spore sacs of the organism were present, for the first time, in large numbers; after three days the sacs were replaced by hyalin bodies considerably larger than those originally in the sacs.

The deduction is made that so-called fatty degeneration in carcinoma is in some part due to the presence of the various forms of the organism which have been mistaken for fat cells.

The fluid of carcinomatous growths was found to consist of practically a pure culture of the organisms, demonstrated especially in malignant ovarian cysts and tumors.

In all scrapings of cancer examined there were found the several forms of the organism, which under favorable laboratory conditions could be followed from the simple "fat drop" type through all stages up to its sporeforming saculation.

Of the utmost significance is the statement of the author that postmortem results justify the declaration "*that all the organs, including the blood taken from the regions of all cases dying of cancer, including sarcoma and epithelioma, contain large numbers of the organisms,*" and that where cachexia is well marked in cases of sarcoma and carcinoma, "*the organism can be detected in the peripheral blood.*"

Considerable space is devoted by the author to crediting the

work of Plimmer (*Practitioner*, April, 1899), and Russell (*Brit. Med. Journ.*, Dec., 1890,) as having a direct bearing upon his own methods and results. He concludes, moreover, that his findings only substantiate and make more definite the findings of the organisms of Plimmer and Russell, which he considers identical with his own.

The work of Dr. Gaylord has been carried over several years in the New York State Pathological Laboratory at Buffalo and it bears the stamp of authentic relation.

The series of speculative and technic developments in experimental medicine promulgated by the earnest laboratory workers in the few years past all point to exactitude in diagnosis and in differentiation hereafter.

For years the diseases of most formidable genesis and of most dreadful results presented to the average medical man a host of impossible attack and of improbable defense. One after another these diseases have been subjected to the process of laboratory investigation and the thorough elucidation of their morphologic and pathogenic history has opened up the way to a rational knowledge of their clinical significance.

To-day the intelligent medical profession is in possession of the detail of the plans of organization in the pathologic strongholds of such diseases as tuberculosis, yellow fever, leprosy and the plague, and our present review would indicate that we are ready to almost assert our possession of the secret of cancer and of its cause and development.

In every center of medical progress, the field of experiment is advancing hand in hand with the clinical exponents and each disease is yielding more and more to the applied knowledge as it reaches the battlefield in the human individual.

We are scarcely ready to take position for universal serum treatment nor to entirely relegate the vast array of remedial measures which our materia medica has evolved; but against those diseases, ever growing in their exact enumeration, associated with or due to organisms of pathogenic habit, there promises to be specific antagonists.

The importance, then of Dr. Gaylord's comprehensive work can not be underestimated and it must stimulate a wider experimentation among the workers, while it must at the same time enthuse a cordial appreciation in those who stand among the audience and who may say, "well done."

Society Proceedings.

ORLEANS PARISH MEDICAL SOCIETY.

Meeting of April 13, 1901.

Owing to the absence of Dr. E. M. Dupaquier, his paper on "Scarlatina; A Case with Bacteriologic Examination; Remarks on Antitoxin" was postponed until the next regular meeting (*q. .v*).

Under report of cases and of medical news Dr. Nelken reported *a case of urticaria*. He spoke of its prevalence at this season and called attention to the fact that the physician seldom sees the disease except when some complication has arisen. In the case reported the swelling was so marked that it resembled the edema of nephritis. A mercurial purge and alkaline diuretic caused all symptoms to disappear, and the doctor reported this case more to promote discussion than because of any unusual features.

Dr. Gessner remembered a case charaterized by recurrent attacks. He had found iron, ergot and nux vomica beneficial.

Dr. Dyer differentiated between the simple and acute cases of urticaria which were easy of relief on account of ability to get at the cause, usually some form of intestinal irritation produced by food or drugs ingested, and the chronic form, known as giant urticaria or angio-neurotic edema, the origin of which is difficult of discovery. He spoke of idiosyncrasies in some persons to certain drugs and odors, and said that even the suggestion of such by word of mouth was sufficient to produce the disease in some. To relieve the intense itching which accompanied both forms he had found nothing so beneficial as the Turkish bath. Of drugs cannabis indica, increasing to even large doses, served the purpose best. He had given as much as twenty (20) drops of the fluid extract every four hours to adults, remembering that of course the physiologic effect of this drug is obtained with such doses. Antipyrin, 3 to 5 grains, and salicylate of soda, 5 grains in three hour dosage were useful.

Dr. McGuire asked if Dr. Dyer had observed an effect on the recurrence of attacks by changes of temperature and men-

tioned a case in which exposure to heat from a cooking stove was apparently the cause of the recurrences.

Dr. Dyer answered that patients complain usually of an exaggeration of the itching on first entering the Turkish bath before sweating begins.

Dr. Feingold mentioned a case of giant urticaria involving both eyes with no visual defect, in which no relief could be obtained except from compression from bandaging. He also recalled a case in which there was huskiness of the voice indicating involvement of the vocal cords.

Dr. Barnett told of a case in a woman of neurotic tendency, in whom some circulatory interference was the cause of chronic urticaria. Bromides and digitalis effected a cure.

Dr. Knolle reported a case in which, after having tried everything recommended in text-books and by his medical friends, the disease was cured by eliminating milk from diet of patient.

Dr. Michinard emphasized Bouchard's doctrine that the ills of life are frequently caused by intestinal absorption, and applied this doctrine to the disease under discussion, recommending free purgation as the principal treatment.

Dr. LeBeuf thought urticaria a frequent manifestation of ptomain poisoning.

Dr. Storck was of the opinion that Dr. Knolle's case was one of tyrotoxicon poisoning.

Dr. Martin agreed that indigestion was the cause of many cases of urticaria. When constipated, the ingestion of shell fish invariably produced urticaria upon him.

Dr. Lazard asked if there was any elevation of body temperature in those cases produced by auto-intoxication.

Dr. Nelken had taken temperature of two cases and had found no elevation.

Dr. Dyer wanted to emphasize the reflex origin of quite a number of cases, admitting that the acute disease is oftenest due to auto-intoxication.

Dr. Martin *showed a device for driving staples into fragments of fractured bones* and exhibited a bone in which fragments were held together by staples.

Meeting of April 27, 1901.

Dr. E. M. Dupaquier read a paper on "*Scarlatina and Diphtheria; A Case with Bacteriologic Examination: Remarks on Antitoxin.*" (Page 755 this number of the Journal).

Discussion: Dr. Theard had found beginning of desquamation delayed until the 13th or 14th day not uncommon in scarlatina. He believed diphtheria is never complicated by scarlatina, though scarlatina may be complicated by diphtheria.

Dr. Oechsner advised varying the dosage of diphtheria antitoxin with the severity and location of the disease, using larger doses for laryngeal cases.

Dr. King believed in using the Politzer bag after rupture of drum membrane, as in these cases additional detritus could thus be removed without danger, the opening in the drum preventing dangerous increase of pressure and dissemination of pus.

Dr. Scheppegrell believed use of the Politzer bag to be dangerous and unnecessary, as in such cases the openings were usually free. Believed strongly in antitoxin for diphtheria. Mentioned a case of unusual stimulation in a little child, who, for alarming collapse, was given whisky ℥x. between 4 and 7 A. M.

Dr. U. S. Bird, of Florida, on invitation, stated that 2000 units usually sufficed in his cases.

Dr. Dyer asked if Dr. Pothier could afford any information concerning the present status of the germ discovered by Class of Chicago. He desired to know especially whether the germ could be easily and rapidly cultivated, and whether it was practically available for differential diagnosis.

Dr. Pothier stated that the Class bacillus is a diplococcus, larger than the gonococcus, and appearing in streptococcal groups. The germ is difficult to cultivate, requiring a special culture medium of garden earth and a jar upon which it grows rapidly. After culture on this medium it grows readily on the ordinary media. Class had experimented with his germ on pigs, and recovered it in the secretions and in the desquamations which followed. In two or three cases in Charity Hospital here a diplococcus has been obtained resembling the Class germ. The diplococcus of Class has been accepted by the Chicago Board of Health, and is used in Chicago to differentiate between

scarlatina and diphtheria, cultures being taken from throat and inoculated directly on the special culture medium of agar and garden earth. From 18 to 24 hours incubation are necessary. The germ has not yet been accepted elsewhere as specific.

Dr. Theard stated that the Chicago Bulletin of Health for March, 1899, discussed the Class diplococcus, and that this bulletin could be gotten on application.

Dr. Pothier, in reply to Dr. Asher, stated that this germ is stained by Gram's method.

Dr. Graner reported a case of mixed infection.

Dr. Pothier remarked that in cases of mixed infection the diphtheria antitoxin was less efficient, and advised the additional use of antistreptococcic serum.

Dr. Barnett has seen good results within 12 hours of the injection of diphtheria antitoxin. Had seen a child drop dead from heart failure, though apparently convalescent, from a mild attack of diphtheria. Effectiveness of antitoxin questionable when injection made after first 24 or 36 hours.

Dr. Perkins insisted on the beneficial effects of antitoxin even in cases where it was used late.

Dr. Barnett would use the remedy freely even in late cases, as it is innocuous.

Dr. Scheppegrell stated that successful cases had been reported in which two antitoxins had been used for mixed infection.

Dr. Callan had used antitoxin in a child 2 months old to a total of 13,500 units. Beneficial effects of antitoxin usually observed in 24 hours, sometimes in 12 hours.

Dr. M. M. Lowe had seen the antitoxin successfully used after 72 hours.

Dr. Dupaquier, in closing, said that no perceptible change from antitoxin occurs in 24 hours. English serums probably weaker than ours, which may account for the larger doses of English writers. Agreed with Dr. Perkins as to good results even in late cases, having seen success follow injection on the fifth day.

Dr. Perkins had never seen antistreptococcic serum used successfully, and asked for the expression of the members.

Dr. Barnett had seen one case in which he thought this antitoxin had been useful.

Dr. Theard had seen it used unsuccessfully in one moribund case of scarlatina.

Dr. Pothier related two successful cases.

Dr. Blum one successful and one unsuccessful case.

Dr. Genella related his experience in attempting, with the consent of the patient, to procure from the druggist a copy of a prescription given his patient by another physician. A general discussion of the matter followed, and the general opinion of the Society seemed to be that the prescription was the property of the patient.

Abstracts, Extracts and Miscellany.

Department of General Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

The Etiology of Cancer.—"This subject of cancer," said Dr. Roswell Park in his recent presidential address before the American Surgical Association, "has been for the pathologist the mystery of the ages, and continues to be the subject of active and profound study in all quarters of the world, with now a promising hope of eventual solution." This hope, has, it appears to us a reasonable basis in the work of recent investigators, as set forth in lately published articles, notably that of Gaylord, Director of the New York State Pathological Laboratory of the University of Buffalo. That carcinoma and sarcoma are dependent upon a parasite seems in the suggestive light of recent researches quite likely, but that it has been demonstrated is certainly not yet true. Many ardent advocates of the parasite theory are in the field, but there are just as competent investigators in the ranks of the opposition, and they are checking up each other's work. So that before long there is good reason to believe we shall have positive proof or disproof of assertions lately made.

The first Annual Report of the Cancer Committee of the Surgical Department of the Harvard Medical School, published Octobter 23, 1900, gives a valuable resume of work done up to that time throughout the world. This report presents fairly both sides of the question and draws the conclusion "that the theory that cancer is due to a parasite is not proven." This conclusion is based largely, it would appear, upon the work of Pianese and others, who have attempted to show that the different bodies found in maglignant tumors "arise either from degenerations of the protoplasm, degenerations of the nuclei, atypical mitosis, or from phagocytosis." Dean using the same technic as Russell seemed to show that the so-called fuchsin bodies were hyaline degenerations and Lack opened the peritoneum of a rabbit and having scraped the ovaries so as to set free ovarian epithelium, closed the cavity and awaited developments. He killed the animal after fourteen months and found a nodule the size of a cherry attached to the uterus with disseminated nodules on the liver, peritoneum and mesentery. The diaphragm was infiltrated with similar masses, and there were nodules in the pleura and a mass in the mediastinum. Histologic examination showed the infiltrated mass to be adenocarcinoma. "This experiment," they remark, "is of extreme importance, because cancer in rabbits is of extremely rare occurrence. If this work can be repeated it bids fair to throw much light on the etiology of cancer."

There are general reasons against the parasitic theory, such as —

1. Cancerous tumors being composed of masses of epithelial cells, if due to a parasite it ought to be shown that this parasite is capable of producing epithelial growth, whereas most parasites and irritants cause proliferation of connective tissue only.

2. As regards metastases, it is usual, almost invariable, that the structures of these secondary growths is of the same character as that of the original growth, regardless of the character of the epithelium of this secondary focus.

3. Attempts to inoculate animals with cancer from human beings have failed.

4. Even in cases where there was apparent success the experiment was inclusive for the reason as pointed out recently by Cullen that it was not done from a culture but from peritoneal fluid which might have actually contained epithelial cells.

On the other hand, there are certain considerations which seem to favor the germ theory of cancer.

1. Increase in the frequency of cancer, sometimes being almost epidemic in character, and certain regions seems to have a larger portion of cancer than others and it seems to attack at times a series of residents in certain houses.

2. The disease extends from the original site to distant parts of the body, in this respect resembling metastases which occur in other diseases known to depend upon bacteria.

3. Finally, there develops in the course of time a cachexia, which favors the idea of the formation of some general toxic substance, which may be due to the action of some parasite.

However, the parasitic origin of malignant tumors can not yet be said to be scientifically demonstrated. It is true that Plimmer's bodies were found in over 80 per cent. of the cases examined by Plimmer, in practically all the cases investigated by Gaylord and in the large majority of the cases reported on by the Cancer Committee of Harvard College, so that, it may be said that they are practically constant in cancerous disease, thus fulfilling one of the demands of etiologic proof; but the crucial test of reproducing the disease has not been satisfactorily accomplished. As the recent elaborate report of Gaylord's investigations in the May number of the *American Journal of Medical Sciences* is that upon which most of the recent claims have been based, it would be interesting for us to see in how far the question has been advanced by his work.

In August, 1898, Roswell Park opened the abdomen of a patient suffering of intra-abdominal carcinoma. The case eventually proved to be one of adeno-carcinoma, "probably arising from the appendix spreading, involving the greater portion of the peritoneal surface of the omentum and mesentery and then undergoing mucoid degeneration." A mass of soft cancerous contents was exposed. The fluid was collected in a sterile tube and found even after two weeks bacteriologically sterile. It contained a large number of small hyalin bodies. These were shown not to be fat and could be observed to pass through a developmental cycle up to a space forming stage. This fluid was injected into animals, in some into the peritoneal cavity, in others into the jugular vein. The former developed no tumor, but peritonitis and enlargement of local lymph nodes,

and their peritoneal fluid contained the same hyalin bodies as did the injected fluid.

One animal injected in the jugular vein was killed fifty days afterwards and its lungs were filled with white nodules which were found to be adeno-carcinomata. Russell's fuchsin bodies were found in the splenic pulp, whilst in the perivascular spaces Plimmer's bodies were found. These were half-grown organisms, similar to those found by Gaylord, and previously by Plimmer, in human carcinoma. Attempts to cultivate these were not successful; but success was met with later, the culture medium giving the best results being that recommended by Celli for the cultivation of amebæ, *i. e.*, a bouillon made with fucus crispus. Other animals were also successfully injected with the peritoneal fluid, but it is not mentioned anywhere in Gaylord's article that any of the cultures made from this fluid or from that of injected animals had given successful inoculations. Plimmer's discovery of these hyalin bodies has been amply confirmed by Gaylord, who very generously and unreservedly accords him the credit, but the work of Gaylord unfortunately does not show that he has completed the chain of proof of the casual relation of these bodies to malignant disease.

In the first place it has not been conclusively demonstrated that though constantly present in the peritoneal fluid of abdominal cancer cases, they may not be accompanied by detached epithelial cells or some other substance, the real cause not yet discovered; in the next place cultures have not been uniformly successful, and in no case has it been conclusively shown that the organism can be inoculated from such culture. The work of Plimmer has certainly been carried forward by Gaylord, and the future, we believe, holds much in store from these investigations, but the question is as yet *sub judice*, although there is now a faint glimmering of the light which shall clear up the dark corners in this difficult pathologic field. We shall await with the greatest interest, nay anxiety, the publication of the full report of Gaylord, to which this now referred to is but preliminary. In the meantime our readers would find it profitable to study the report of the Harvard Cancer Committee, the article of Gaylord, and finally the recent address of Roswell Park before the American Surgical Association.

The admirable work already done shows beyond cavil the wisdom of the New York Assembly in establishing this laboratory under state control with sufficient funds to carry out any needed pathologic, chemic or biologic investigations.

Department of Obstetrics and Gynecology.

In charge of Dr. P. Michinard, assisted by Dr. C. J. Miller, New Orleans.

Puerperal Insanity.—Arthur C. Jelley (*Boston Medical and Surgical Journal*) states that puerperal insanity is said to occur once in four hundred deliveries. The great predisposing cause of insanity in general is heredity. It should be looked for in the collateral as well as in the direct lines of the family; and epilepsy, apoplexy and various nervous diseases must not be overlooked since they lead to instability of a sort that is liable to cause a break down during any period of distress. Tuberculosis is often found in the family history, and must be admitted to be an important predisposing cause; also alcoholism, because if it exists to any great extent in either patient it may lead to those neurotic conditions which predispose to insanity. Epilepsy or even profound hysteria may possibly be responsible. The physical condition seems often the only important etiologic factor. The most important division of the subject is, How many cases are clearly septic? Dr. Chapin attributes the decrease from ninety-nine very acute cases admitted to the Philadelphia Hospital in the ten years preceding 1877 to twenty such cases in the ten years preceding 1897 to the stricter antiseptic measures in obstetric practice. In other large institutions a similar decrease has been noted.

In Boston a decrease has occurred, but Jelley states that an examination of the most acute cases, some of which were clearly septic, fails to show a coresponding decrease. It seems fair to assume that in Boston prevention of sepsis has played a less important part than some other factors in the reduction. In this connection it has been suggested that a state of the pelvic organs resulting from previous disease may be the starting point for a septic process in spite of perfect technic of the obstetri-

cian. It is a fact that certain cases of excitement which have been attributed to profound exhaustion are clinically like septic cases, except that the temperature is not so high and there is no vaginal discharge. By analogy it seems probable that when careful clinical and accurate laboratory studies are made simultaneously upon the same cases, we may find a sort of puerperal insanity due to auto-intoxication. Such a group might include many case now attributed to exhaustion.

Course and Outcome—After a short period many of the most excited cases become quiet and no longer suffer from hallucinations. The change is often so sudden that it has been mistaken for alcoholic insanity. Clouston writes that 75 per cent. of his puerperal cases recovered completely, while 8 per cent. died; that 90 per cent. of these recoveries were in six months, that 77 per cent. of his lactational cases recovered, 80 per cent of them in six months, and that 60 per cent. of the insanity of pregnancy recovered. Krafft-Ebing gives the average duration of hospital cases due to pregnancy and lactation at nine months, and eight months for puerperal cases. Many septic cases are of short duration and end in death.

Recurrence.—Thirty patients had more than one attack. In six, all the attacks were puerperal. In eight the first attack was puerperal. In five the first attack was not puerperal.

Prognosis.—The prognosis as to life is very good. In his collection, 13 died in the first attack, 3 in the second, and 14 chronic cases. The prognosis is variously stated from 70 to 80 per cent. in asylum cases, and since many mild cases never go to asylums, it is probably near 90 per cent. The insanity of pregnancy does not appear with delivery. Clouston says of insanity in general, that he looks upon a temperature of 100 and over with alarm in any form of mental disease, and in the estimation of the intensity of brain overaction, one-half a degree is equivalent to two degrees in the measurement of a febrile disturbance. The return of menstruation is a good sign, as it indicates return to a normal condition.

Treatment.—Special attention should be paid to prophylaxis. If conditions are favorable to its development, the most perfect hygiene possible in the home should be insisted upon. Sleep is very important, and the digestive and eliminative organs should be carefully attended to. Serious mental disturbance during pregnancy is not to be regarded as an indication for inducing

labor. The author deals at length with the general points of treatment, and calls attention to the advantages of private or public hospital treatment.

New Method of Repairing Vesicovaginal Fistula.—Spassokenkosky (*Centralblatt für Gynäkologie, No. 25*) describes the following method of procedure in a difficult case; six sutures were passed through the vesical mucosa and subjacent connective tissue around the edge of the fistula. By making traction upon these the opening was inverted into the vagina, so that it was easy to split the edges with a scalpel without injuring the mucosa. A catheter was passed into the bladder, the ends of the sutures threaded into its eye and drawn through the meatus, thus uniting the mucous edges and bringing them in apposition. The vaginal edges were then sutured in the usual manner, after which the provisional ligatures were withdrawn through the urethra. The catheter was not left in the urethra. Five cases treated by this method were entirely successful.

—*Am. Journ. of the Medical Sciences*, December, 1900.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Contagiousness of Pneumonia.—The history of pneumonia epidemics, in towns, barracks, households, etc. (The farthest back related by Shekins in 1348, the latest of quite recent date), has settled the question not only of the infectiousness but also of the contagiousness of pneumonia, the proof, of course, being based on bacteriologic researches. Both the practising and teaching bodies of the profession by a large majority admit to-day that pneumonia under certain circumstances becomes contagious; yet rarely of course, as compared with the number of pneumonia cases observed. It is a fact, however. Not only is the contagiousness of pneumonia a settled principle in the practice of medicine, according to current text books, but boards of health on the European continent are now considering (see Bulletin of the Academy of Medicine, Paris 1900, Prof. Graucher) the necessity of including pneumonia in the number

of contagious diseases requiring official measures, just like smallpox, diphtheria, measles, scarlatina, typhoid etc. Contagious pneumonia is communicated by the pneumococcus, from the sick to the healthy, through any avenue of entrance, and the origin of contagious pneumonia need not necessarily come from a pneumonia since contagious pneumonia may be started by contact with any other pneumococcic case, such as a pneumococcic otitis or any pneumococcic abcess, just like erysipelas of the face, which is caused by streptococcic infection (Fehleisen's long streptococcus), may be originated by contact with any other streptococcic case, such as a phlegmas of the arm or puerperal septicemia.

Direct contagion (sputum alive with active pneumococci during attack, other fluids of the patient also carrying the germs, at times) may occur long after the acute attack is over (30 days to two years, says Netter).

Indirect contagion (clothing, bedding, and other things that were in contact with the patient) may be carried by a healthy person.

Transmission of pneumonia also occurs from the mother to her fetus (Thomer, Strachan, Marchand, Netter) and from the mother to her child through breast-nursing (Bozzolo, Aymard).

Whatever may be the mode of contagion in pneumonia, it requires the concurrence of two essential conditions, namely: *increase in virulence* on the part of the specific germ, *decrease in resistance* on the part of the economy.

Diverse and yet unknown causes increase the virulence of the pneumococcus; circumstances due to seasons, lowering of temperature of the atmosphere, alterations in atmospheric pressure and the hygrometric state of the atmosphere.

Decrease in resistance is congenital, chiefly racial (negroes); but, most often it is acquired (syphilis, grip, inhalation of metallic particles, asthma, bad hygiene). Special *clinical* features pertain to contagious pneumonia.

First, the duration of *incubation* is eminently variable, but it averages five days. From the second day the infected individual is liable to infect others, contagion during incubation having been proven as it was conclusively in the case of eruptive fevers.

After a silent incubation, a single chill as in ordinary pneumonia, or in many instances a series of repeated chilly sensations, announce the outset. Constitutional symptoms are sim-

ilar to those of other severe intoxications. Defervescence is tardy, from the fifteenth to the seventeenth day, and convalescence lingers. But the usual termination is death, from the second to the twenty-third day. Complications are frequent: grey hepatization, profound alterations of the nervous system, invasion of the blood current by the pneumococcus and consequent generalized pneumococci. The prognosis is, therefore, extremely grave. Treatment is consequently prophylactic, aiming at staying the dissemination of the contagion, in view of which the professional and public minds must be impressed with the notion of contagiousness in pneumonia. Measures shall be taken to disinfect sputum by means of five per cent. solutions of formol or hot alkaline solutions rather than with bichloride solutions. Patient's mouth must be rigorously disinfected, not only during attack but after recovery, to prevent re-infection of the same individual and infection of others. Nurses and attendants must wear a gown in the sick room, wash their hands after touching a soiled article, take their meals out of the sick room and rigorously disinfect their bucco-pharyngeal cavities.

Walls of the sick room must be whitewashed, floor scrubbed with strong antiseptic solutions, hangings and furniture carefully disinfected with formol or steam under pressure. If remarks are made, recall the heavy mortality from pneumonia and broncho-pneumonia rising to thousands in Paris (Professor Graucher) yearly, and insist upon the fact that much good is derived from a little care and inconvenience.—Thesis of Dr. M. A. Jossu, Paris, 1901.—*Gazette des Hôpitaux*, March 12, 1901.

Department of Therapeutics.

In charge of Dr. J. A. Storck, New Orleans.

Ice-Bags in Pneumonia.—For several reasons it seems that the ice-bags are more practical than the cold compresses, which are recommended by Niemeyer. In the first place they are dry, and do not wet the bed-clothing; second, their cold effects are more uniform and decided, because they retain a low tempera-

ture longer; and, third, it is not necessary to change them oftener than every two or three hours unless the patient has a high degree of fever. This not only saves work, but obviates the "troublesome manipulation" referred to by the writer named below.

How, then, is cold to be applied, and how long must it be continued? The affected area is to be surrounded with ice, contained in rubber bags, which are wrapped in thin towels. If there is a great deal of fever the towel is to be omitted. The number of ice-bags which are to be applied in any case depends on the degree of fever which is present and on the size of the area which is inflamed. If the fever is not very high and the disease is confined to the front and lateral base on one side only, two bags should be applied over this area, and as a precautionary measure another bag should be applied to the opposite base; for pneumonia appears to have a tendency to involve the corresponding area on the other side. If the exudation extends to the side and back, and for a considerable distance upwards, three or four bags should be applied front, laterally and as far back as possible. If the affection is extensive, and involves both lungs, put on as many ice bags as are necessary to cover the whole area. One of the worst patients in the author's experience required nine bags to cover the whole chest, sides and front, and at the same time two bags were applied to the head. The length of time during which cold is to be applied depends in a great measure on the degree of the fever which is present. If the temperature falls to or near the normal point, and shows a tendency to remain there, the ice may be gradually removed. It is best, however, not to remove all the ice bags, even though the temperature is normal, unless the crisis is at hand without question, because if they are all taken away before the proper time the temperature will rise again and it is brought down with greater difficulty the second than it was the first time. There is more risk in taking the ice off too soon than in allowing it to remain too long. Sometimes, the application of ice to a certain area is followed by amelioration of the physical signs and symptoms, when all at once the temperature makes an ascent. Care should be taken to find out whether or not the inflammation has extended to a new field, and if this is found to be the case it should be followed up by applying more

ice-bags to the newly invaded territory, and the temperature will in all probability fall (Pulmonary Consumption, Pneumonia and Allied Diseases of the Lungs, by THOMAS J. MAYS, A. M., M. D. Treat & Company, N. Y. 1901, page 469).

METHYL SALICYLATE (Synthetic Oil of Wintergeen) is still a favorite agent with many observers. Its successful results in rheumatic affections still continue to be reported, and yet again disappointment is not lacking from other quarters. Its most satisfactory field of usefulness appears to be that of an alternate with other well-known remedies applicable to this affection.

Dr. Edmund Rottenbiller, of Trencsen, Austria-Hungary, reports on the use of this agent in 122 cases of acute rheumatism. He made use of the natural oil of wintergreen, but takes pains to state that he is not prejudiced at all against the synthetic product. He found no difficulty in getting all the patients to take this agent, and none of the disagreeable symptoms which usually follow the administration of the salicylates were noted (*Klin. Therap. Wochensch.*, Vol. vii, p. 582).

Reports continue to be made of the successful use of this agent in the treatment of orchitis.

The late Dr. B. Pillsbury, of Middletown, N. Y., reported the following case of poisoning by this agent:

"I report this case since I find, among such records as I have examined, but one case of poisoning by oil of wintergreen, that one ending in recovery. Gilbert G——, a middle-aged farmer, took by mistake for whisky two ounces of oil of wintergreen, at 4 P. M. He went about his work, but in two hours began to have a copious diarrhea, which continued constantly until his death. His daughter, with rare good judgment, gave him mustard as an emetic, the whites of a dozen raw eggs, milk, and very little water. It was not until near 9 P. M. that a doctor arrived. He found the patient sweating prodigiously, feeling as if on fire inside; pulse 100, not intermittent; the skin was aflame. On the following day the skin was still intensely red, and the victim was harassed by a terrific itching. In the afternoon the pulse was still non-intermittent, but running as fast as possible. The odor of oil of wintergreen was perceptible in the fecal evacuations. Death occurred from exhaustion forty-one hours after the wintergreen was taken.—*New York Medical Record*—Squibb's *Ephemeris*.

Serum Injection in the Cure of Cancer.—It will be remembered that Wlaeff, of St. Petersburg, last summer stated that he had discovered a serum the injection of which would cure cancer. This serum he made from cultures of the blastomycetes, or ferment extracts of cancerous tumors, and he employed it in a number of malignant cases inoperable because of the size of the tumor, and the extent of the glandular involvement; of the two cases presented by him in illustration of the potency of his treatment, the first received six injections in the course of a month and showed some improvement, operation was performed, but the cicatrix ulcerated. This ulceration healed under the influence of renewed injections, though the glandular engorgement did not disappear, requiring removal by the knife.

Another patient suffering from extensive epithelial involvement of the tongue was apparently markedly benefited by the injections and his pains greatly lessened. Championnière saw one patient with epithelioma and enormons ganglion engorgement greatly improved by six mouths' treatment; also a woman suffering from cancer of the breast, who stated that following the injections she experienced greater comfort and more freedom of movement.

With a spirit worthy of emulation Berger and Reynier (*Journal des Practiciens, No.* 48, 1900), placed a number of patients suffering from inoperable cancer under Wlaeff's care, keeping these patients under careful and almost constant surveillance during the course of the treatment. They were not able to note a cure in a single case, though the patients always were greatly improved by the treatment, and they felt benefited by it. The tumor seemed to diminish somewhat in volume. A cancer of the rectum exhibited a lessened tendency towards hemorrhage, and several cancers of the tongue showed less salivation and edema. There was a decided diminution in the amount of pain. Several patients gained weight, and in others the progress of emaciation seemed to be ameliorated. Indeed, the malignant disease seemed to become for the time arrested, but this arrest was never followed by a cure, nor was there any reason to hope or suppose that a cure would ultimately result. The action of the injection seemed to be transitory, since when patients who had experienced any relief stopped treatment, the symptoms at once became more pronounced. Championnière points out that

many forms of treatment have been heralded as curative because of a similar arrest in the progress of disease. He notes that the administration of magnesia has, in his own experience, been followed by this result, and believes that he has even seen a cure. Jaboulay holds, that large doses of sulphate of quinin will produce this result.—*The Therapeutic Gazette.*

Psychic Influence in the Practice of Medicine—"A legitimate practice of medicine," says Dr. J. C. Culbertson in the *Journal of the American Medical Association* (March 9), "takes cognizance of all psychic influences and turns them to account in the treatment of disease. The personal influence of a physician should always be firm, not vacillating, positive and never negative. These attributes tactfully administered are sedative and may be anesthetic and narcotic. They possess the therapeutic property of being able to allay irritability and excitement. The wise man who is a successful practitioner uses his personal influence as a stimulant, sedative, anodyne, narcotic, anesthetic, and nervine, and does it systematicaly, as though it were as important a therapeutic measure as the giving of a tonic, purgative or opiate. It is this personal influence that makes some men great and others small. All that is known of the entire materia medica, as well as other resources in the art and science of medicine, are as wide open to the command of one physician as of another, and the differentiation between them is founded upon but two accomplishments: ability to diagnose pathologic conditions and a systematic use of personal influence in the treatment of disease. All other therapeutic aids are but valuable adjuncts, not one of which is to be for one moment in the slightest degree deprecated, for they are co-factors of the greatest importance. It is this systematic use of the personal influence of the physician that gives any foundation to Christian Science or faith curists. Eliminate this one powerful agent and there is nothing left of a visionary vagary."

Department of the Ear, Nose and Throat.

In Charge of Dr. A. W. de Roaldes and Dr. Gordon King, New Orleans.

Abortive Treatment of Acute Mastoiditis in Adults and Children.—Kernon, of New York, in a communication to the American Society of Laryngology, Rhinology and Otology, relates his experience with the application of heat and cold to the mastoid process in the abortive treatment of acute inflammations of that bone. In ten cases, four of whom were children, he applied heat by means of hot water passed through the Leiter coil and failed to observe any diminution in the pain or the inflammatory process. The substitution of ice water applied in the same manner rapidly relieved the pain, and with the aid of thorough drainage of the middle ear and frequent cleansing with a 4000 sublimate solution, had the effect of aborting the suppuration in the mastoid cells. Absolute repose is enjoined, and if swelling of the posterior upper wall of the meatus is apparent, this part is freely incised with the meatus. This constitutes what is now known as the "Internal Wilde's Incision." If the perforation in the tympanic membrane is not large enough to permit of free drainage it is enlarged. If after thirty-six hours the pain and fever continue unabated, opening of the mastoid is indicated. A proper prognosis is much aided by a bacteriologic examination. The author claims that 80 per cent. of cases in which streptococci are found require opening of the mastoid.

Tuberculous Empyema of the Maxillary Antrum.—Koschier, of Vienna, relates the history of a patient who came to him with symptoms of empyema of the antrum, for the treatment of which an opening through the alveolus was drilled. Further examination showed the cavity of the antrum to be divided into two distinct compartments, only one of which proved to be filled with pus. Probing of that cavity also revealed the presence of necrosed and exfoliated bone. Later the antrum was opened widely through the canine fossa and a mass of pus and granulation tissue removed with a curette. The granulation

tissue was examined histologically and found to be of tuberculous nature, and the bacilli were also discovered, affording positive proof of the tuberculous nature of the disease.

Tuberculosis of the Maxillary and Sphenoidal Sinuses Causing Death.—Panse reports the case of a young girl, 16 years of age, who came to consult him for recurrent nasal polypi, which he proceeded to remove in the usual manner. One month later the patient returned to him completely blind, and thinking he had to deal with a lesion of the optic nerve resulting from frontal sinus disease, he trephined these cavities. No pus was found, but considerable loss of bone was revealed in the region of the ethmoidal cells, with the presence of granulation tissue. The operation was stopped and the patient subequently given antisyphilitic treatment. Ophthalmoscopic examination revealed bilateral optic neuritis. The treatment proving ineffectual, and the presence of giant cells in the granulations having been at last discovered, a second attempt was made to remove the diseased parts surgically. The nose, the frontal and maxillary sinuses, and the ethmoidal cells were thoroughly cleaned of all granulation tissues and caseous masses, the dura covering the frontal lobes of the brain being exposed freely by the operation. The immediate result was encouraging, but the patient grew worse later and died in coma. Autopsy revealed extensive tuberculous involvement of all the accessory cavities and the meninges.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

Hemophilic Extravasation into the Conjunctiva, Antrum and Cheek, Associated with Habitual Constipation.—The woman, aged 26 years, had three previous attacks, milder in character, the first when 7 years old. Breathing was obstructed by intranasal swelling, and the antrum closed intermittently. There was constant hemorrhage from theconjunctiva and mouth for two days, and oozing for two days more, being relieved by

ergot and adrenal extract. Cauterization of the inferior turbinate and the establishment of free catharsis caused rapid improvement, the absorption of the facial edema being synchronous with the re-establishment of free breathing and increased oxidation.

Recurring Hemorrhages from the Ciliary Body in a woman, aged 26 years, who suffered from habitual constipation. The patient, first noticed three weeks before, a small black spot before the right eye, which gradually increased in size until a ring was seen on looking upward, followed soon afterward by complete obscuration of vision. Had two previous attacks at intervals of a year, both following periods of constipation varying from three to ten days, the constipation preceding the present attack being more than usually obstinate. There was also obstructed breathing from intranasal swelling. Blood-clots on the posterior capsule prevented a view of the fundus. The symptoms would indicate bleeding from a ciliary vessel occurring between the hyaloid membrane and the posterior capsule of the lens. The associated constipation bears out the observation of Eales, of Birmingham, who claims that such hemorrhages are due to this cause. Under free purgation, pilocarpin sweats, and iodide internally, the hemorrhage has begun to be absorbed. Reported by Dr. Ziegler, *Section of Ophthalmology, College of Physicians*, Philadelphia.

Purulent Choroiditis in a 2-year old boy who had suffered from a severe attack of mumps four weeks before. There was deep-seated yellowish reflex behind the pupil, and the entire uveal tract became infiltrated with pus. A diagnosis of metastatic choroiditis was made. Secondary glaucoma and commencing staphyloma in the ciliary region necessitated enucleation. On examination of the eye-ball by Dr. Shumway there was accidentally discovered a minute rusty particle of iron, 1 *mm.* in diameter, which responded to the chemical tests with hydrochloric acid and potassium ferrocyanid. Study of the microscopic sections showed rupture in the anterior capsule of the lens, splitting up of the lens fibers, a corresponding rupture in the posterior capsule, and a bluish line in sections subjected to the Perl test, apparently denoting the track of the

iron. In the absence of any history of traumatism, the attack of purulent choroiditis in a young child convalescing from mumps was naturally interpreted as metastatic choroiditis. It was found on later investigation that the child had played in a blacksmith shop during convalescence, and, although there was no history of an accident, the iron evidently entered the eye from the anvil, giving rise to panophthalmitis. It was fortunate enucleation was promptly done, and sympathetic trouble thus prevented. Reported by DR. CARPENTER, *Section of Ophthalmology, College of Physicians of Philadelphia.*

USE OF PILOCARPIN IN THE TREATMENT OF INFLAMMATIONS OF THE EYE.—Dr. H. F. Hansell read a paper giving the history of a number of cases and methods employed in the treatment. The cases were those of interstitial keratitis, traumatic purulent iritis, vitreous opacities, and retinochoroiditis. In most of the patients the improvement had been most rapid and marked, while in all the treatment had proved beneficial. He expressed regret that the treatment had not been more generally followed in chronic deep-seated ocular inflammations where the usual routine treatment was most prolonged or unsuccessful, and felt sure from his increased experience that many of these forms of inflammation and of loss of vision could, with few exceptions, be materially improved. The recovery in some of the cases described was most satisfactory. The most striking was that of case No. 1, of traumatic purulent kerato-iritis, in which the intense injection had decidedly cleared and the large collection of pus in the anterior chamber altogether disappeared in 24 hours, with complete recovery in one week.—*Ibid.*

METHYL-ALCOHOL AMAUROSIS, the Pathway of Entrance of the Poison being the Lungs and the Cutaneous Surface:

The man, aged 39, was a varnisher by trade. Two months prior to his amaurosis he had been constantly employed in shellacking, and was accustomed to dilute the shellac to the desired thinness with methyl-acohol. He was, therefore, almost uninterruptedly during the working hours of this period exposed to the fumes of the wood-spirit, and was also accustomed at the end of his day's work to wash his hands, forearms and face with the same liquid in order to remove the shellac stains.

Dr. de Schweinitz drew particular attention to the dangers which workers in this liquid ran, and thought that they, as well as their employers, should be properly warned. He pointed out the analogy between these dangers and those which were encountered by workers in lead, nitrobenzol and dinitrobenzol and how in the last three named trades all proper precautions were taken to prevent the well-known toxic action of these drugs.
—*Ibid.*

Medical News Items.

The Commencement Exercises of the Medical Department of Tulane University were held at the Grand Opera House in New Orleans, May 1, 1901.

There were 126 graduates in medicine and eleven graduates in pharmacy. The exercises were notable for the fact that the usual valedictory was omitted and from the extraordinary features of the occasion in the introduction of the new president into the graduation ceremonies and in the marked distinction conferred upon the Dean, Prof. Stanford E. Chaillé, upon whom was conferred the degree of LL.D. by Tulane University. The friends of the Dean, and the Journal among them, are all free to congratulate Prof. Chaillé upon this recognition of his long service to the institution he has in so large degree fostered. His connection with the Medical Department since 1858 as a teacher, professor and dean was duly noticed in becoming resolutions from the faculty and from the student body. The recipient of the several tokens of esteem delivered himself of a characteristic speech of acceptance of these.

The address was delivered by the Hon. J. Hannis Taylor, on the Relation of the Medical Profession to International Law.

The New Orleans College of Dentistry held the Second Annual Commencement of the institution, at Tulane Hall, on Monday night, May 6, 1901. Four gentlemen were graduated before an interested audience. Appropriate addresses were delivered by the officers, faculty and graduates. Dr. George L. Viallon, of Louisiana, delivered the salutatory; Dr. David

2:30 P. M., Monday, June 3. This association, as implied in the name, consists of medical editors of the United States. Meetings are held annually, coincident with the Americal Medical Association. The aims of the association are the advancement of medical journalism, the foundation of an ethical press in medicine, and the improvement of the medical profession in general. The membership includes the leading medical writers and editors of the country.

THE MISSISSIPPI STATE MEDICAL EXAMINING BOARD passed seventy-eight of 125 applicants for a license to practice medicine.

A COPY OF THE TEXAS MEDICAL PRACTICE LAW, recently passed, may be had for 20 cents in stamps by addressing the *Texas Medical Journal*, at Austin, Texas.

THE AMERICAN SURGICAL ASSOCIATION, at its recent meeting in Baltimore, elected the following officers: President, Dr. De Forest Willard; first vice president, Dr. Robert Abbe; second vice president, Dr. R. Matas; treasurer, Dr. Geo. R. Fowler; secretary, Dr. Dudley P. Allen; recorder, Dr. Richard H. Harte. The next meeting will take place at Albany, N. Y., May 20, 1902.

THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION has changed the dates of its next meeting to the 12th, 13th, and 14th of September. This change has been made necessary because the dates first selected conflicted with another large association meeting at the same place.

The meeting is to be held at the Hotel Victory, Put-in Bay Island, Lake Erie, Ohio, and the low rate of one cent a mile for the round trip will be in effect for the meeting. Tickets will be on sale as late as September 12, good returning without extension until September 15. By depositing tickets with the joint agent at Cleveland and paying 50 cents the date can be extended until October 8. This gives members an opportunity of visiting the Pan-American Exposition at Buffalo, to which very low rates by rail and water will be in effect from Cleveland.

Full information as to rates can be obtained by addressing the secretary, Dr. Henry E. Tuley, No. 111 West Kentucky

street, Louisville, Ky. Members of the profession are cordially invited to attend this meeting.

Those desiring to read papers should notify the secretary at an early date.

A Psycho-Physiological Laboratory in the Department of the Interior at Washington is the basis of a set of resolutions urged for adoption by medical associations at the instance of Mr. Arthur McDonald, connected with the United States Bureau at Washington. The objects aimed at are the study of children from the psycho-physic standpoint, in the hope that a better knowledge of pedagogic methods may result in a higher psychic man in the social sphere.

The University of Pennsylvania projects a new Medical Laboratory, to cost $500,000 or more. The plan of its building provides for all fields of laboratory research in medical and collateral fields.

Pasteur Institute in the South.—Acting upon the resolution and approval of the Georgia State Medical Association, a Pasteur Institute has been established in Atlanta. Thirteen persons have already received treatment.

Personal.—Dr. W. A. Holloway has removed from Rosedale to Plaquemine.

Dr. U. S. Bird, of Tampa, Fla., and Dr. E. A. Blount, of Nacogdoches, Tex., were in New Orleans, recently.

The New Orleans Polyclinic closed May 31, after a most successful session. There were 174 altogether in the class. The fifteenth annual session will begin November 4.

The Rates to St. Paul, for the American Medical Associaciation meeting, etc., will be one fare plus $2 for the round trip.

Dioxogen is the name now given to the Oakland hydrogen dioxid, to prevent confusion with other products.

The Farbenfabriken of Elberfeld Co. have obtained a favorable outcome of the suit directed at their use of the term phenacetin and their defence of the product against imitations and substitutions. A circular issued by them gives the legal proceedings and result.

The Minnesota State Board of Medical Examiners have issued a circular with printed list of their rules for conducting Medical examinations. These are explicit and comprehensive. Points of particular notice are:

Every one is required to pass the examination; no reciprocity clause. Candidates from all schools have questions in common except in Materia Medica on which questions adapted to particular schools are given. If more than half of the branches are successfully passed, candidates shall be re-examined only on these branches in which they have failed.

The State Normal School has issued handsome invitations to their Commencement, one of which the Journal is pleased to acknowledge.

Book Reviews and Notices.

All new publications sent to the Journal *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* Journal *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Diseases of the Nose and Throat. By D. Braden Kyle, M. D. Second Edition, Revised. W. B. Saunders & Co., Philadelphia, 1901.

This work represents the second edition of that admirable volume on diseases of the ear, nose and throat, published by this able writer in 1899, and so well received by the profession at that time. The ready sale of the first edition soon exhausted the supply and the author found it necessary to have issued a second lot, which he saw fit to extend and revise to be consistent with the march of progress in this branch of medicine. The value of the work is already established, as is its high standard among the text-books of the day, and it should find a deserving place in every medical library. De Roaldes and King.

A Manual of Hygiene and Sanitation, by Seneca Egbert, A. M, M. D. Second Edition. Lea Bros. & Co., Philadelphia and New York, 1900.

Most physicians will welcome a readable work on hygiene and sanitation, and the more so when it is practical as well. Each chapter in the

book before us is both interesting and instructive, and all evidence the careful reading of the author. Beginning with the consideration of the simpler essentials of domestic hygiene, the work expands in the consideration of sanitation from the personal and public standpoints. Food, school hygiene, ventilation and personal hygiene are all considered. The chapter on quarantine is full of information relating to general questions, but including specific information on special diseases, and describing the U. S. government's relation to the whole subject of quarantine. Chapters follow on military hygiene, disinfection and the disposition of sewage, all being questions of general interest, and by no means least to physicians. The illustrations are not numerous, but are inserted for explanatory purposes.

DYER.

A Dictionary of Medical Science, by ROBLEY DUNGLISON, M. D., LL. D, Revised and enlarged by RICHARD J. DUNGLISON, A. M., M. D. Lea Bros. & Co.. Philadelphia and New York, 1900.

The twenty-second edition! Need much more be said? A fundamental purpose of the author was "to make the work not a mere lexicon of terms, but to afford under each a condensed view of its various medical relations, and thus render it an epitome of the existing conditions of medical science." This was over seventy years ago. The author succeeded, the reviser has kept up the good work, and this edition, which is fittingly prefaced by a portrait of Dr. Robley Dunglison, is as complete as any.

In our student days, if information was sought, the advice was not to seek in a dictionary, but to "look in Dunglison." It has been so since. The excellence of the present edition means it will probably be so for some time to come.

C. C.

PUBLICATIONS RECEIVED.

Transactions of the American Pediatric Society, edited by Walter Lester Carr, M. D., Washington, 1900.

Report of the State Charity Aid Association, November, 1900.

The Acute Contagious Diseases of Childhood, by Marcus P. Hatfield, M. D.—G. P. Engelhard & Company, Chicago, 1901.

A Syllabus of New Remedies and Therapeutic Measures, by J. W. Wainwright, M. D.—G. P. Engelhard & Co., Chicago, 1901.

Municipal Sanitation in the United States, by Charles V. Chapin, M. D.—Snow & Farnham, Providence, R. I., 1901.

Induction Coils, by H. S. Norrie.—Spon & Chamberlain, New York, 1901.

Report of the Board of Administrators of the Charity Hospital, New Orleans, 1900.

The Eleventh Annual Report of the Eye, Ear, Nose and Throat Hospital, 1900.

Urinary Diagnosis and Treatment, by John W. Wainright, M. D.—G. P. Engelhard & Co., Chicago, 1900.

Diseases of the Heart, by Albert Abrams, M. D.—G. P. Engelhard & Co., Chicago, 1900.

Manual of Therapeutics, Parke, Davis & Co., Detroit, Michigan, 1900.

Transactions of the American Orthopedic Association, 1900.

A Practical Treatise on Materia Medica and Therapeutics, by John W. Shoemaker, M. D.—F. A. Davis Company, Philadelphia, New York and Chicago, 1900.

Medico-Surgical Aspects of the Spanish-American War, by Nicholas Senn, M. D.—American Medical Association Press, Chicago, 1900.

Rudiments of Modern Medical Electricity, by S. H. Monell, M. D.—Edward R. Pelton, New York, 1900.

Ninth Annual Report of the Sheppard and Pratt Hospital.

Bulletin of the Indiana State Board of Health.

Introduction to the Study of Medicine, by G. H. Roger, M. D.—D. Appleton & Co., New York, 1901.

Physical Diagnosis in Obstetrics, by Edward A. Ayers, M. D.—E. B. Treat & Co., New York, 1901.

Reprints.

A Report of Twenty-four Operations Performed During Spinal Analgesia by William Seaman Bainbridge, M. D.

A Plan for the Study of Man—Susceptibility to Disease and Physical Development in College Women, by Arthur McDonald.

Imperfect or Deficient Urinary Excretion as Observed in Connection with Certain Diseases of the Skin, by L. Duncan Bulkley, M. D.

A Contrtibution o the Bottini Operation for the Radical Relief of Prostatic Obstruction, by L. Bolton Bangs, M. D.

The Anti-Tuberculosis Crusade and the Sanatorium Movement in the United States During the Year 1900, by S. A. Knopf, M. D.

Affections of the Eye and Its Appendages in Bright's Disease, by William Cheatham, M. D.

Excision of High Rectal Carcinoma Without Sacral Resection—Compound Fractures, by N. Senn, M. D.

Degenerative Results of Defective Heredity, by Charles Denison, M. D.

Corneal Corpuscular Activity, by Joseph E. Willets, M. D.

Medical Education — The Deep Fascia — Anatomy of Hanging — Typhoid Fever and Our Water Supply, by Edmund W. Holmes, M. D.

A Study of Shortening of the Tibia and Femur in Fifty Cases of Tuberculous Disease of the Hip Joint, by Russell A. Hibbs, M. D.

Report of the Committee on a State Board of Health, Texas State Medical Association, 1900.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR APRIL, 1901.

CAUSE.	*White.*	*Colored.*	*Total.*
Fever, Malarial (unclassified)	....	....	....
" " Intermittent	5	2	7
" " Remittent	....	....	....
" " Congestive	....	....	....
" " Typho	....	....	....
" Yellow	....	....	....
" Typhoid or Enteric	3	3	6
" Scarlet	4	....	4
Bronchitis	7	5	12
Diphtheria	....	....	....
Influenza	4	1	5
Measles	....	....	....
Whooping Cough	2	....	2
Pneumonia	19	18	37
Cancer	8	4	12
Consumption	36	41	77
Diarrhea (Enteritis)	16	6	22
Dysentery	7	5	12
Hepatic Cirrhosis	6	....	6
Peritonitis	4	1	5
Debility, General	1	....	1
" Senile	20	4	24
" Infantile	3	2	5
Bright's Disease (Nephritis)	26	8	34
Small Pox	1	4	5
Heart, Diseases of	40	22	62
Apoplexy / Congestion of Brain	14	6	20
Meningitis	9	3	12
Tetanus, Idiopathic	....	....	....
" Traumatic	....	....	....
Trismus Nascentium	....	....	....
Injuries	20	7	27
Suicide	3	2	5
All Other Causes	70	42	112
TOTAL	324	185	509

Still-born Children—White, 18; colored, 19; total, 37.

Population of City (estimated)—White, 210,000; colored, 90,000; total, 300,000.

Death Rate per 1000 per annum for month—White, 18.51; colored, 24.66; total, 20.36.

METEOROLOGIC SUMMARY.

(U. S. Weather Bureau.)

Mean atmospheric pressure 30 02
Mean temperature ..... 66.
Total precipitation, inches 7.79
Prevailing direction of wind, northwest.

UNIVERSIT

FOR REFERENCE

NOT TO BE TAKEN FROM THE ROOM

BRODART CAT. NO. 23 012 PRINTED IN U.S.A.

22730